Kentucky
UNBRIDLED SPIRIT™

Medicaid EHR Incentive Program

Eligible Hospital Meaningful Use Attestation Manual

October 1, 2013
Version 1.3

KENTUCKY EHR | INCENTIVE PROGRAM

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Record Of Changes

Changed Section	Description	Updated by	Update Date	Release
9.2	Added a home page	EHR Team	5/22/2012	1.25
9.3	Updated the CMS/NLR screen	EHR Team	5/22/2012	1.25
3.1 4	Included “preceding” 12 months Expanded definition to include Title XXI-CHIP (but not separate CHIP encounters	TLT	1/18/2012	1
6 7 11	Links updated	TLT	1/18/2012	
11.2	Stages of MU Grid	TLT	1/18/2012	
11.4	Preceding 12 months drop down menu screen added Verbage included in explanation	TLT	1/18/2012	
11.5	MU Questionnaire Screen Added	TLT	1/18/2012	
12	Requirements for MU Measures for EHs Updated to reflect current measures. Links updated	TLT	1/18/2012	
12.1	Meaningful Use Measure Menu Screen Added with functionality detail	TLT	1/18/2012	
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12.8	Meaningful Use Core Measure 7 Screen added with functionality detail. Additional Measure included for 2013 changes.	TLT	1/18/2012	
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13.9	Meaningful Use Menu Measure 6 Screen added with functionality detail and suggested option name added	TLT	2/8/2012	
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14	Meaningful Use Clinical Quality Measures Screens added	TLT	1/18/2012	

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19.1.3	Document Upload Tab with functionality detailed	TLT	1/18/2012	
19.1.4	Outcome Tab Added with functionality detailed	TLT	1/18/2012	
19.2	Attestation Appeals Added	TLT	1/18/2012	
20	Further Information on Meaningful Use Link updated	TLT	1/18/2012	
9.4	Added the word “consecutive” to the patient volume information and added 3(i) (ii) (iii), as well as 17 (i) (ii) (iii)	TA	10/1/2013	
10.49	The number sequence was incorrectly listed as “10.80”. I corrected it to “10.49”	TA	10/1/2013	
10.50	The number sequence was incorrectly listed as “10.81”. I corrected it to “10.50”	TA	10/1/2013	

1 INTRODUCTION

The Kentucky Medicaid EHR Incentive Program provides incentive payments to eligible professionals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The purpose of this document is to provide instructions for eligible hospitals, CAHs, or eligible professionals to register for and complete attestation for the Kentucky Medicaid EHR Incentive Program using the KYSLR system.

Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at **http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf**
- Kentucky State Medicaid HIT Plan (SMHP) Version 3.0 located at **http://chfs.ky.gov/NR/rdonlyres/1158A0F3-B33E-44F5-B774-6A7B9D53D493/0/KY_SMHP_v3_10072011.pdf**
- Kentucky Medicaid EHR Application Portal located at **https://prd.chfs.ky.gov/kyslr/**
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at **http://www.cms.gov./EHRIncentivePrograms/**
- Office of the National Coordinator for Health Information Technology located at **http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204**

Regional Extension Centers (RECs) have been designated to provide technical assistance to Kentucky EH and CAHs. The RECs that provide a full range of assistance related to EHR selection and training are listed below:

- **Northern/Northeastern Kentucky – Tri-State REC**
  Website: **http://www.healthbridge.org/rec**
  Phone: 513-469-7222 Option 3 or 4
  E-mail: **info@healthbridge.org**

- **Northeast Kentucky – Northeast Kentucky Regional Information Organization (NeKY RHIO)**
  Website: **http://www.nekyrhio.org/nekyrhio/**
  Phone: 855-385-2081 or 206-824-0481
  E-mail: admin@nekyrhio.org

- **Rest of Kentucky – Kentucky REC**
  Website: **http://www.ky-rec.org/**
  Phone: 888-KY-REC-EHR or 859-323-3090
  E-mail: **kyrec@uky.edu**

If you would like more information on the measures required for Meaningful Use please see the site below:
http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage

Revisions

Original 12/17/2011
Revised 3/26/2012
Revised 4/1/2013
Revised 10/1/2013

2 BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at **http://www.healthit.hhs.gov**.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Kentucky Department for Medicaid Services (DMS) works closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at **http://www.cms.gov/EHRIncentivePrograms/**. The site provides general and detailed information on the programs, including tabs to guide users on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

3 ELIGIBILITY

While EHs can begin the program in Calendar Year (CY) 2013, they must begin the program no later than Federal Fiscal year (FFY) 2016.

The first tier of provider eligibility for the Kentucky Medicaid EHR Incentive Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the KY MMIS provider data store does not correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program, the provider will receive an error message with a disqualification statement.

At this time, CHFS DMS has determined that the following hospitals are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program:

- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children's Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

Additional requirements for the EH/CAH

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment or
2. A children's hospital (exempt from meeting a patient volume threshold).

Hospital-based providers are not eligible for the EHR incentive program.

Qualifying Providers by Type and Patient Volume

Program Entity	Percent Patient Volume over Minimum 90-days
Acute Care Hospital	10%
Children's Hospital	Patient Encounter definition expanded to include TXXI-CHIP encounters (but not separate CHIPs)

3.1 Out-of-State Eligible Hospitals/CAHs

The Kentucky Medicaid EHR Incentive Program welcomes any out-of-state Eligible Hospital/CAH to participate in this program as long as they have at least one physical location in Kentucky. Kentucky must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state Eligible Hospitals/CAHs must make available any and all records, claims data, and other data pertinent to an audit by either the Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

3.2 Establishing Patient Volume

An eligible provider must annually meet patient volume requirements to participate in Kentucky's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (but not separate CHIPs). All EH and CAHs should calculate patient volume based on TXIX - Medicaid and/or TXXI-CHIP and out-of-state Medicaid patients.

3.2.1 Patient Encounters Methodology

- EHs - To calculate TXIX DMS patient volumeThe total TXIX DMS and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year OR the preceding 12 months by:
  - ✓ The total encounters in the same 90-day period.
  - ✓ Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period. (*Please note per CMS FAQ nursery days are excluded from inpatient bed days*)
  - ✓ An emergency department must be part of the hospital.

Eligible Hospital DMS Encounter Definition

For purposes of calculating eligible hospital patient volume, a DMS encounter is defined as services rendered to an individual 1) per inpatient discharge, or 2) on any one day in the emergency room where TXIX and TXXI-CHIP DMS (but not separate CHIPs) or another state's Medicaid program paid for :

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

4 PAYMENT METHODOLOGY FOR ELIGIBLE HOSPITALS

Statutory parameters placed on Kentucky Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children's hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Kentucky is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Kentucky Medicaid incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Kentucky MMIS (or other automated claims processing systems or information retrieval systems); and
- Hospital financial statements and hospital accounting records.

The Kentucky Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

$$\boldsymbol{EH\ Payment = Overall\ EHR\ Amount \times Medicaid\ Share}$$

Where:

Overall EHR Amount = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

Medicaid Share = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

Kentucky intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Kentucky Medicaid payments. The reason for this approach is that most of Kentucky's numerous rural hospitals operate on a very thin margin and need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Kentucky has worked with CMS on ways to effectively calculate costs. For example, charity care costs are not included on Kentucky's cost report. Kentucky has received approval from CMS to use the Kentucky Medical Assistance Program (KMAP) disproportionate share form data in lieu of cost reports for this data. A standard questionnaire is used to determine the disproportionate share.

To the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the state to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges— charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

5 PROVIDER REGISTRATION

If this is your second year with the EHR incentive program, then there is no need to register with CMS. You may log in directly to the KYSLR to attest for Meaningful Use using the link **http://chfs.ky.gov/dms/ehr.htm**.

EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at **http://www.cms.gov/EHRIncentivePrograms/**.

Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN.

Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. EHs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the KYSLR system to attest for Kentucky's Medicaid EHR Incentive Program. DMS will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify DMS of a provider's choice to access Kentucky's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the KYSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Kentucky DMS. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, NLR will be notified by DMS that a payment has been made.

6 PROVIDER ATTESTATION PROCESS AND VALIDATION

DMS will utilize the secure KYSLR system to house the attestation system. The link will only be visible to providers whose type in the MMIS system matches an EHR incentive eligible provider category. If an eligible provider registers at the NLR and does not receive the link to the attestation system within two business days, assistance will be available by contacting the DMS Provider Enrollment Call Center Operations at: (502) 564-5472.

The following is a description of the information that a provider will have to report or attest to during the process.

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at **http://www.cms.gov/EHRIncentivePrograms/**, the EH will be asked provide:
    - Completed patient volume information on the KYSLR Web site;
    - Completed Hospital EHR Incentive Payment Worksheet;
    - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules).

2. The EH will be asked to attest to:
    - Adoption, implementation or upgrade of certified EHR technology or meaningful user;
    - Not receiving a Medicaid incentive payment from another state.

3. The EH will be asked to electronically sign the amendment;
    - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify); and
    - The person filling out the form should enter his or her name.

***Note**: For providers that are ready to demonstrate Meaningful Use in year 1, the provider will attest to this fact.*

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, DMS will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the EH to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

During the first year of the program is the only time an EH will be allowed to attest to adopting, implementing or upgrading to certified EHR technology. It should be noted that the documentation for AIU of certified EHR technology for EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at **http://www.healthit.hhs.gov**). EHs can attest to either AIU or meaningful use as appropriate.

All providers will be required to attest to meeting meaningful use to receive incentive payments after attesting to the Adopt, Implement, or Upgrade for the first time.

7 INCENTIVE PAYMENTS

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and validation by DMS, an incentive payment can be approved. Providers will be notified of approval for payment by email to the email address submitted with registration. Please be sure that the email provided is current.

8 PROGRAM INTEGRITY

DMS will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should be sure to keep their supporting documentation.

8.1 Administrative Audits and Appeals

You may appeal the determination made by the Kentucky Department for Medicaid Services on your incentive payment application. Please send a Formal Letter of Appeal to the address below, within 30 days of the determination date of notification. This formal written notification must include a detailed explanation of why the EP or EH deems a wrong determination made by the Kentucky Medicaid EHR Incentive Program. Any supporting documentation to the appeal should be included with the Letter of Appeal.

Division of Program Integrity
Department for Medicaid Services
275 E. Main Street, 6E-A
Frankfort, KY 40621

9 GETTING STARTED

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the National Level Registry (NLR) at http://www.cms.gov/EHRIncentivePrograms/. This registration is only needed once, if this is your second year of the EHR Incentive Program then you may go directly to the KYSLR sight shown below.

The hospital provider then begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system at http://chfs.ky.gov/dms/ehr.htm (sign-in screen shown below) and entering the NPI and CMS-assigned registration identifier that was received from CMS.

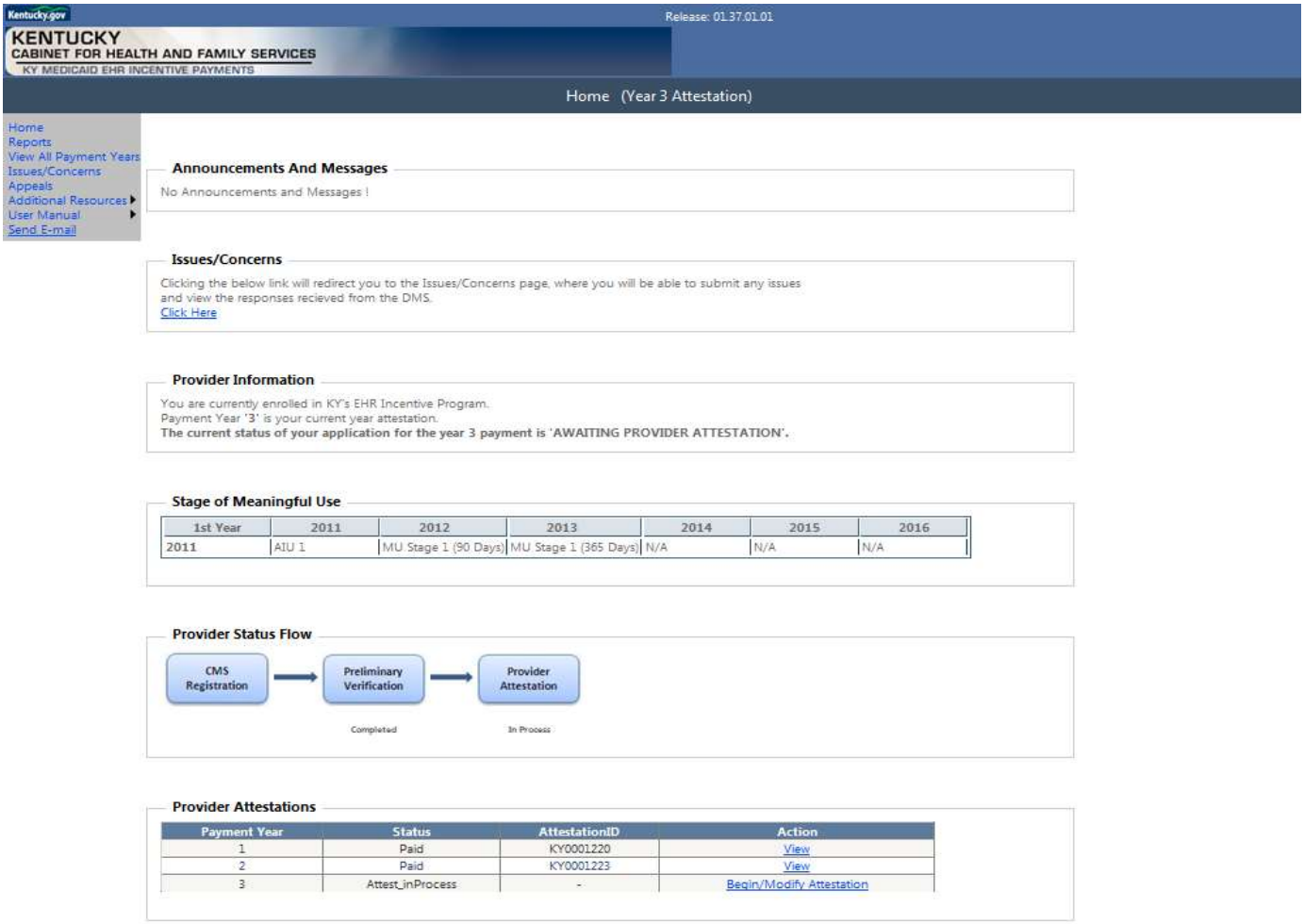
9.1 Eligible Hospital Sign-in Screen

The provider will enter the NPI registered on the NLR and the CMS-assigned Registration Identifier that was returned by the NLR. Please allow 48 hours from registration to log into the KYSLR. The EH will only need to register once, if you are a returning provider you will be able to log in at any time.

If the data submitted by the provider matches the data received from the NLR, the CMS/NLR Provider Demographics Screen will display with the pre-populated data received from the NLR. If the provider entry does not match, an error message with instructions will be returned.

9.2 Eligible Hospital Home Screen

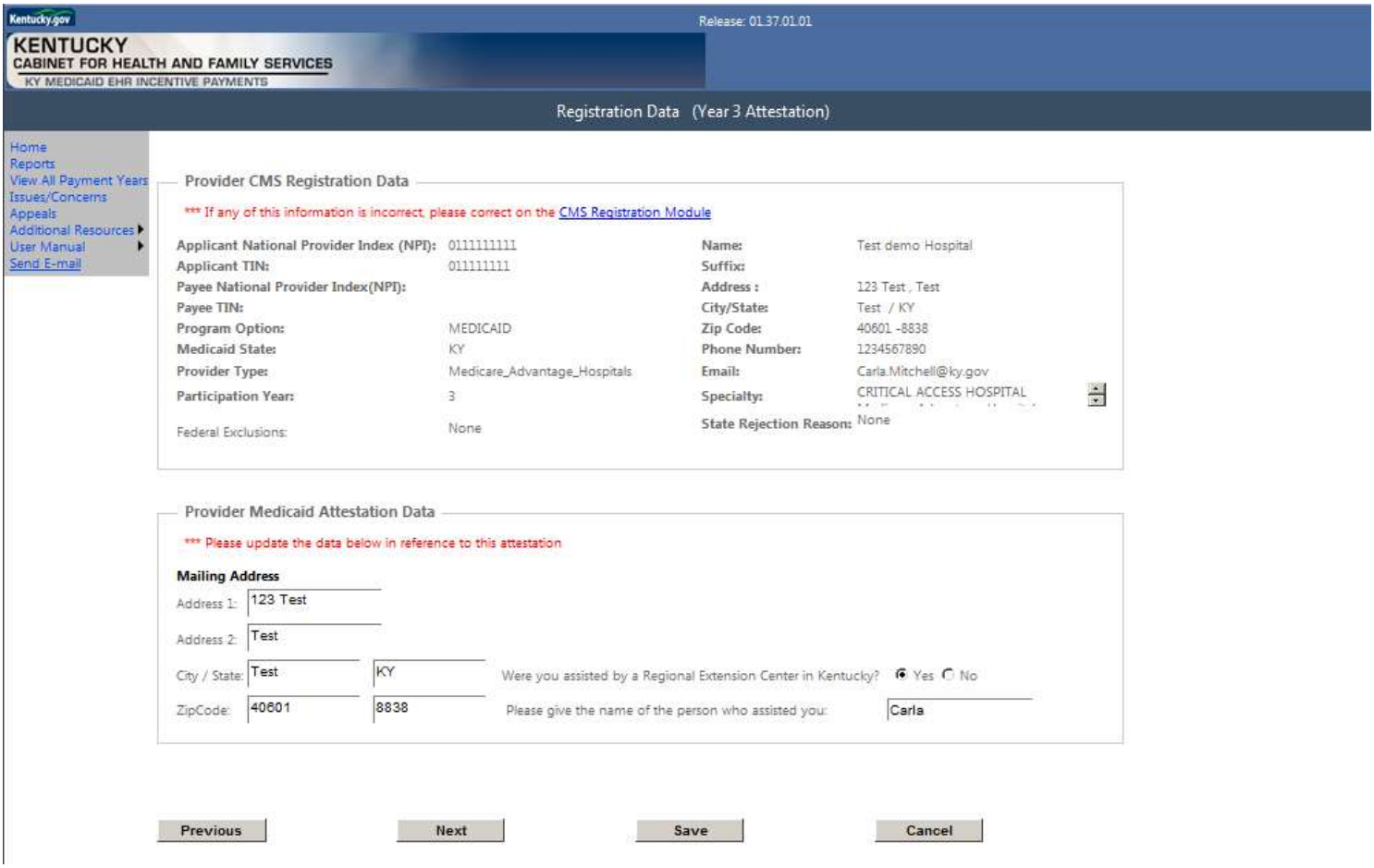
The Home screen will give the EH data about their current KY Attestation as well as provide navigation for the EH to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment.



There are six sections to the Home page listed below:

1. **Announcements and Messages** – This will be the first section on the page if a message or announcement exists for the provider.
2. **Issues/Concerns** – This will be the second section on the page. The Issues / Concerns will provide a link for the provider to redirect to the Issues / Concerns page if he would like to submit a new issue or view a response to an issue.
3. **Provider Information** – This is the third section of the home page. The provider information will give the high level status for the provider, the current payment year and the current status for the payment year.
4. **Stage of Meaningful Use** – This is the fourth section of the home page. This grid will supply which stage of Meaningful Use you will need to attest to according to the program year you are attesting.
5. **Provider Status Flow** – this is the fourth section of the home page. The Provider Status Flow will give a diagram showing the provider where he is in the current year's attestation. If the provider has been found not eligible for any reason, he will also find the specific reasons for that finding in this section.
6. **Provider Attestations** – this is the fifth section of the home page. The Provider Attestation table will list the providers attestations by payment year and list the navigation actions he has available for each.

9.3 Registration Data Screen



Along with the pre-populated data from the CMS Registration Module there are additional fields that can be updated by the provider.

The data provided by the CMS Registration Module is view only. If any of this data is incorrect then the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected in the screen above. The fields that are from the CMS registration are listed below:

- **Applicant National Provider Index (NPI)** – This is the eligible hospital or CAH's registering NPI. The NPI registered at CMS should be the same NPI that is enrolled in KY Medicaid.
- **Applicant TIN** – This is the Tax Identification Number that was listed in the CMS registration. This TIN should be the same TIN that is listed for the provider under KY Medicaid.
- **Payee National Provider Index (NPI)** – This is the payee NPI given during the CMS registration.
- **Payee TIN** – The tax identification number associated with the payee NPI.
- **Program Option** – This is the program option that was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.

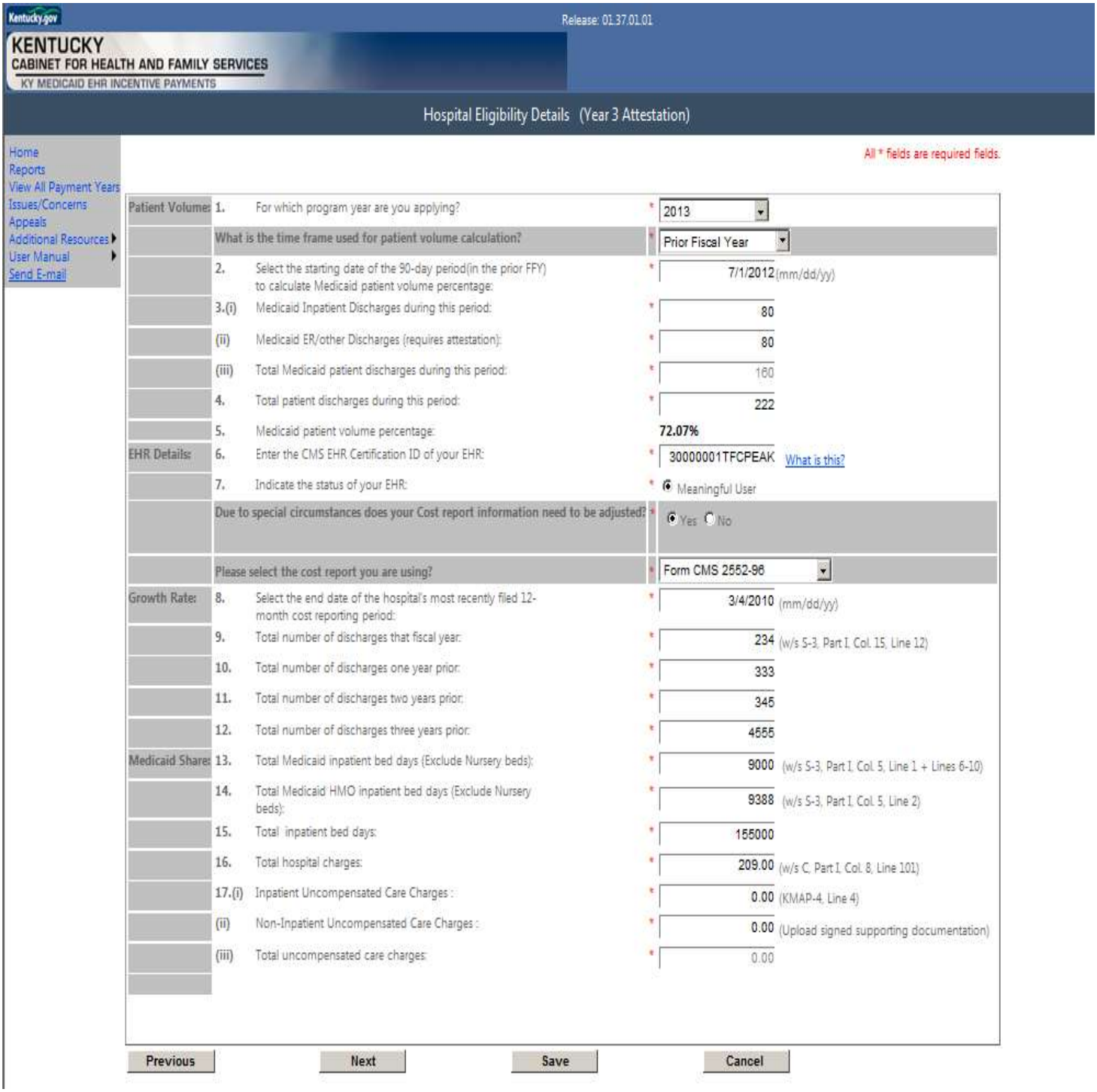
- **Medicaid State** – This is the State that was selected during the provider's registration.
- **Provider Type** – This is the provider type that was given during the registration at CMS.
- **Participation year** – This is the provider's participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.
- **Name** – The Provider's name listed on the CMS Registration
- **Address 1** – The provider's street address listed on the CMS registration
- **Address 2** – The provider's street address listed on the CMS registration
- **City/State** – The provider's city/state listed on the CMS registration
- **Zip Code** – The provider's zip code listed on the CMS registration
- **Phone Number** – The provider's phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- **Email** – The provider's email given during the CMS registration. This email address is used for system generated emails on updates for the provider's attestation and communication from the EHR review staff.
- **Specialty** – The provider's specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

The data listed under the section **Provider Medicaid Attestation Data** is updatable by the provider during attestation. Once the attestation is submitted by the provider the data will become view only. Those data fields are described below:

- **Medicaid ID** - This field only displays if you have multiple Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky Medicaid Numbers. **This Medicaid Number will be used to for your incentive payments.**
- **Mailing Address** - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence. Indicating a new address in these fields will change the Payee address for the Provider's EHR incentive payment.
- **Were you assisted by a Kentucky Regional Extension Center** - Response to this question is required. If the response is yes, then please type the name of the person who assisted you during the attestation process.

9.4 Hospital Eligibility Details Screen

Eligible Hospitals must enter four categories of data to complete the Eligibility Details screen including patient volume characteristics, EHR details, growth rate, and Medicaid share. Hospitals will see the following data on the screen:



Patient Volume

1. Select the program year you wish to attest.
    - This should be either the preceding 12 months OR it can be the prior Federal Fiscal year if the current date is between 10/1 – 12/31.
2. Starting date of the consecutive 90-day period to calculate Medicaid patient volume percentage
    - This date should be a consecutive 90-day period within the Federal Fiscal Year OR the preceding 12 months prior to the program year selected above.
3. (i) Medicaid Inpatient discharges during this period

    (ii) Medicaid ER/other discharges during this period

    (iii) Auto-caluculation of (i) and (ii)
4. Total patient discharges during the period
5. Medicaid patient volume percentage (auto-calculated)

EHR details

6. EHR certification ID of EHR
7. Status of your EHR – Choices:
    - (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
    - (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
    - (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
    - Meaningful User - currently meaningfully using certified EHR technology and are prepared to attest to Meaningful Use and Clinical Quality Measures.

Growth rate

→ *After* attestation Year 2 and forward: Due to special circumstances does your cost report information need to be adjusted – This should only be yes if the data used to calculate your original payment included nursery or swing bed days or you have been working with the Hospital Division due to another issue and requested that you update this information.

→ Select the Cost Report you are using. (ie. Form CMS 2552-96)

8. End date of the hospital's most recently filed 12-month cost reporting period
9. Total number of discharges that fiscal year
    - On the cost report documents this will be w/s S-3 part I, col. 15, line 14
10. Total number of discharges one year prior
11. Total number of discharges two years prior
12. Total number of discharges three years prior

Medicaid share

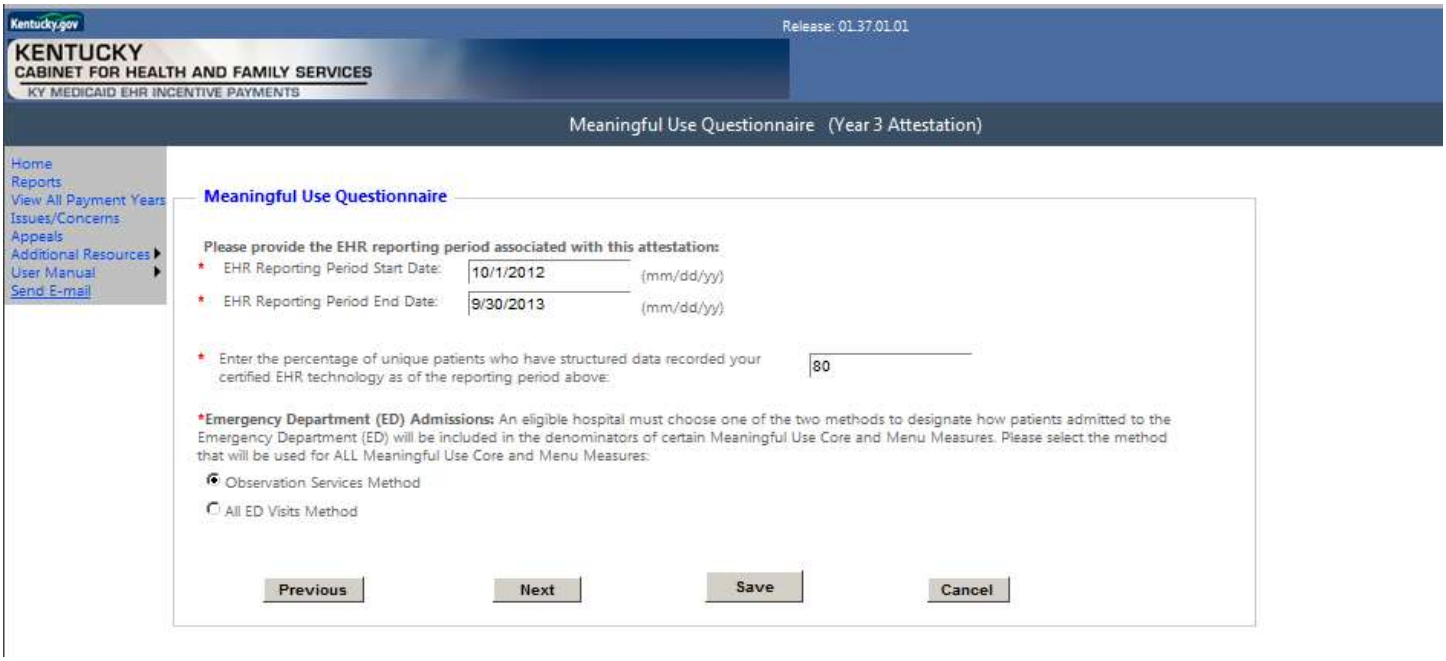
13. Total Medicaid inpatient bed days
    - On the cost report documents this will be w/s S-3 part I, col. 7, line 14 and per CMS FAQ 10668 (FAQ 3315) should not include nursery/swing bed days
14. Total Medicaid Health Maintenance Organization (HMO) inpatient bed days
    - On the cost report documents this will be w/s S-3 part I, col. 7, line
15. Total inpatient bed days
    - On the cost report documents this will be w/s S-3 part I, col. 8, line
16. Total hospital charges
    - On the cost report documents this will be w/s c part I, col. 8 line 202
17. (i) Inpatient ucompensated care charges

    (ii) Non-Inpatient uncompensated care charges

    (iii) Total uncompensated care charges (auto-calculated)

9.5 Meaningful Use Questionnaire Screen

After entering the provider eligibility details, EHs who have selected Meaningful Use will be directed to the Meaningful Use Questionnaire screen.



***Note**: if you are registered as a dual eligilble hospital you must complete your MU attestation with Medicare prior to entering your attestation with Medicaid.*

The following fields are required to continue with the attestation:

1. **Enter EHR Reporting Period Start Date** – This is the starting date for the period of time you are reporting your Meaingful Use Measure data.
    - If you are attesting as a dual eligible hospital then this date should be the same date as the one that was attested for your Medicare Meaningful Use attestation. The system will locate the file from Medicare from this date and you will not be requested to re-enter those measures already submitted to Medicare
2. **Enter EHR Reporting Period End Date** – This is the end date for the period of time you are reporting your Meaningful Use Measure data.
    - If you are attesting as a dual eligible hospital then this date should be the same date as the one that was attested for your Medicare Meaningful Use attestation. The system will locate the file from Medicare from this date and you will not be requested to re-enter those measures already submitted to Medicare
3. **Enter the percentage of unique patients who have structured data recorded in your certified EHR technology as of the reporting period above.**
    - This should be the percentage of all the patients you have seen in service location(s) with Certified EHR Technology who have data recorded in your EHR.
        - This can be calculated by dividing the number of patients with structured data in your Certified EHR by the total number of patients seen at service location(s) with Certified EHR Technology. Multiply by 100 to obtain the percentage. The amount of patients with structured data stored in your EHR should be at least 80%.
4. **Emergency Department (ED) Admissions -** Indicate the method that designates how patients admitted to the ED will be included in the denominators of certain Meaningful Use Core and Menu Measures.

10 REQUIREMENTS FOR MEANINGFUL USE MEASURES FOR EHS

12 out of 12 Core Meaningful Use measures must be met according to the CMS threshold.

- Exception – If CMS allows exclusion to a measure and the EH attests to that exclusion then that measure is still considered completed

5 out of 10 Menu Measures must be met according to the CMS threshold (including exclusions) and At least 1 of the 5 Menu Measures met by the EH must be from the Public Health List.

- Exception - If an EH meets the criteria for and can claim exclusion for both of the public health menu measures, the EH must still select one public health menu measure and attest that the EH qualifies for the exclusion. **This exclusion will count toward the 5 required menu measures. In Kentucky the Immunization Registry is available through KHIE.
- EH must select the remaining 4 that relate to his/her practice, if exclusion applies to one of the measures selected the EH has to attest that the other measures did not relate to his practice or they also would have been exclusions.
- CMS encourages eligible hospitals to select menu measures on which they can report and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they can qualify or if there are no remaining menu measures on which they are able to support

EH must attest to 15 of 15 Clinical Quality Measures

- CMS has expanded the definition of a Meaningful User of certified EHR technology. EHs beyond their first year must report 15 out of 15 CQMs this has been removed as an objective from previous years and is now mandatory
    - No patients in the measure population; It is acceptable to report zero in the denominator, even for 1 or more measures, as long as that is the value displayed & calculated by the certified EHR. The EH attests to this fact.
    - Beginning in 2014 the automated reporting of the clinical quality measures will be accomplished using certified EHR technology interoperable with the systems designated by CMS to receive the data for the Medicare until then CQMs for Medicaid will continue to be submitted through the attestation process until otherwise specified by the State.

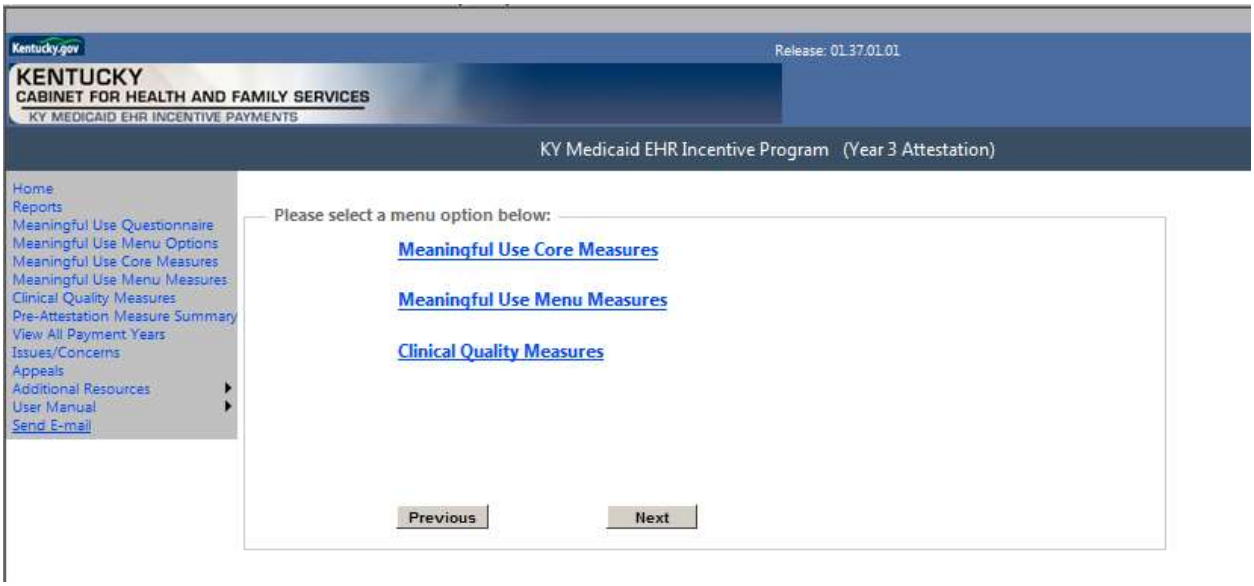
For additional information on Meaningful Use Measures Please see the following CMS Web site below: **http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html**

Measure Screen Tip: If the page seems to be cutting off words on the measure then do the following steps:

- While holding down the 'Ctrl' key press the '-' key until you can see the entire screen.

10.1 Meaningful Use Measure Menu Screen

The menu screen will only allow the user to select a group of measures as they are available. For Example once the Meaningful Use Core Measures are completed, the Meaningful Use Menu Measures will be active to select.



Navigation:

Meaningful Use Core Measures Link – Takes the EH to the first screen of the Meaningful Use Core Measures, active link.

Meaningful Use Menu Measures Link - Takes the EH to the first screen of the Meaningful Use Menu Measures, only active after the MU Core Measures are completed.

Core Clinical Quality Measures Link – Takes the EH to the first screen of the Core Clinical Quality Measures, only active after the MU Menu Measures are completed.

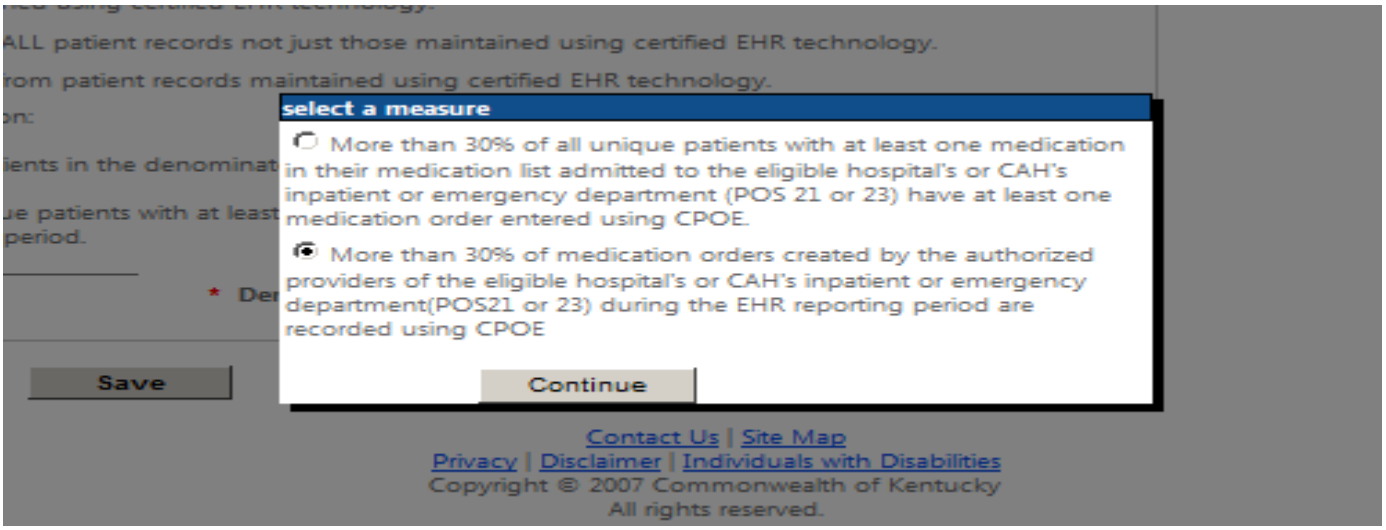
10.2 Meaningful Use Core Measure 1 Screen

Medication List and Medication Orders

Please select from one of measures:

- More than 30% of all unique patients with at least one medication in their medication list seen by the EH have at least one medication order entered using CPOE.

- More than 30% of medication orders created by the EH during the EHR reporting period are recorded using CPOE.



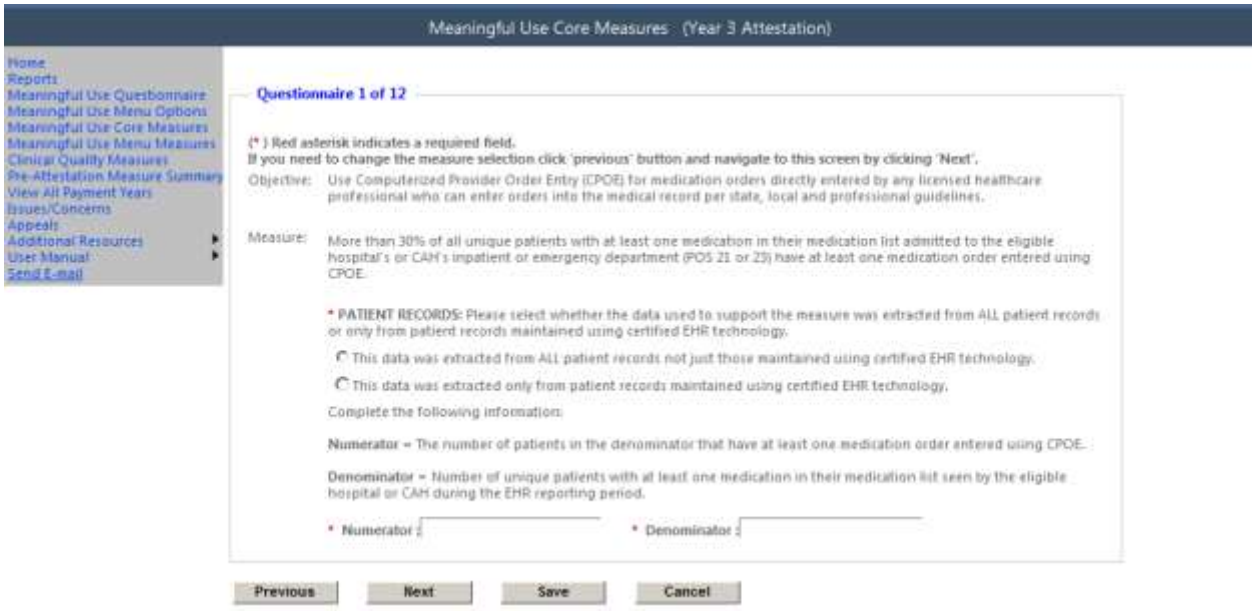
All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure. If the exclusion is not selected, the following details other requirements of this screen:

- The Numerator and Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- EH must meet the >30% threshold, N/D > 30%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.2.1 First Alternate Measure Screen

Depending on your selection, all fields must be completed before the EH can proceed to the next measure.



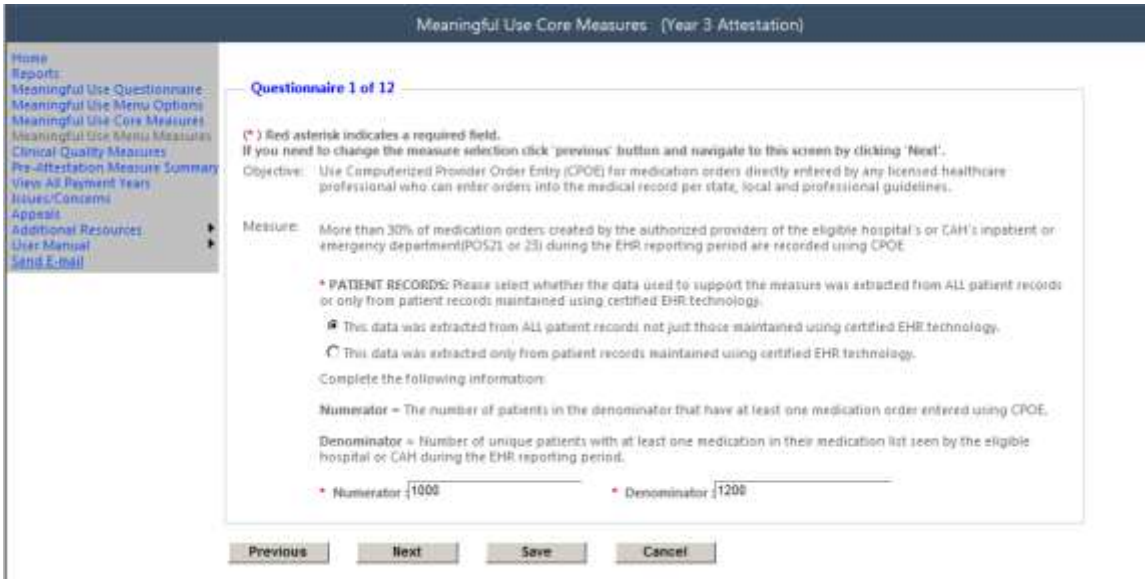
The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >30% threshold, N/D > 30%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.2.2 Second Alternate Measure Screen

Depending on your selection, all fields must be completed before the EH can proceed to the next measure.



The following details other requirements of this screen:

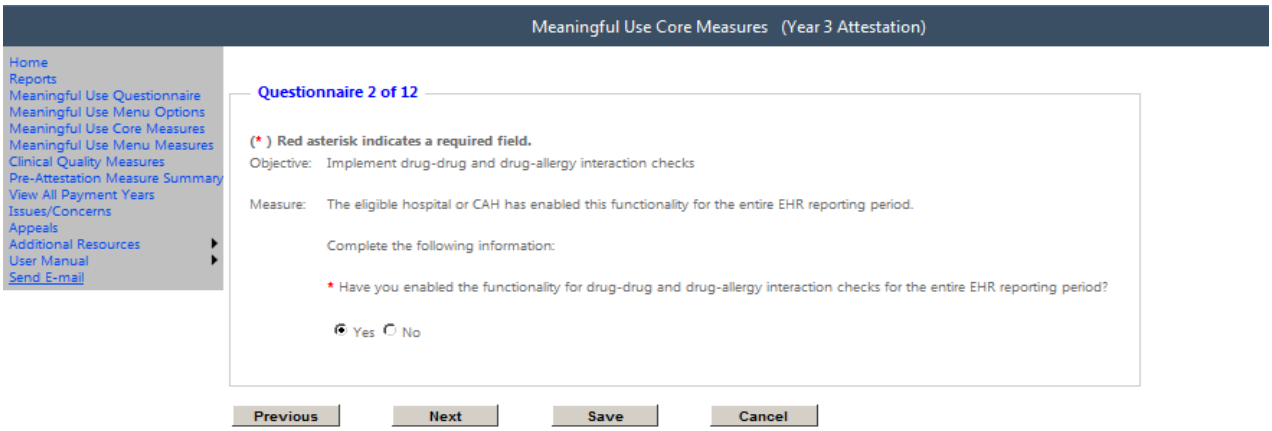
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >30% threshold, N/D > 30%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.3 Meaningful Use Core Measure 2 Screen

Drug-Drug and Drug - Allergy Interaction

Questionnaire 2 is for the implementation of drug-drug interaction check. The provider is prompted with the question, "Have you enabled the functionality for drug-drug interaction checks for the entire EHR reporting period?" Please select Yes or No to continue to the next screen.

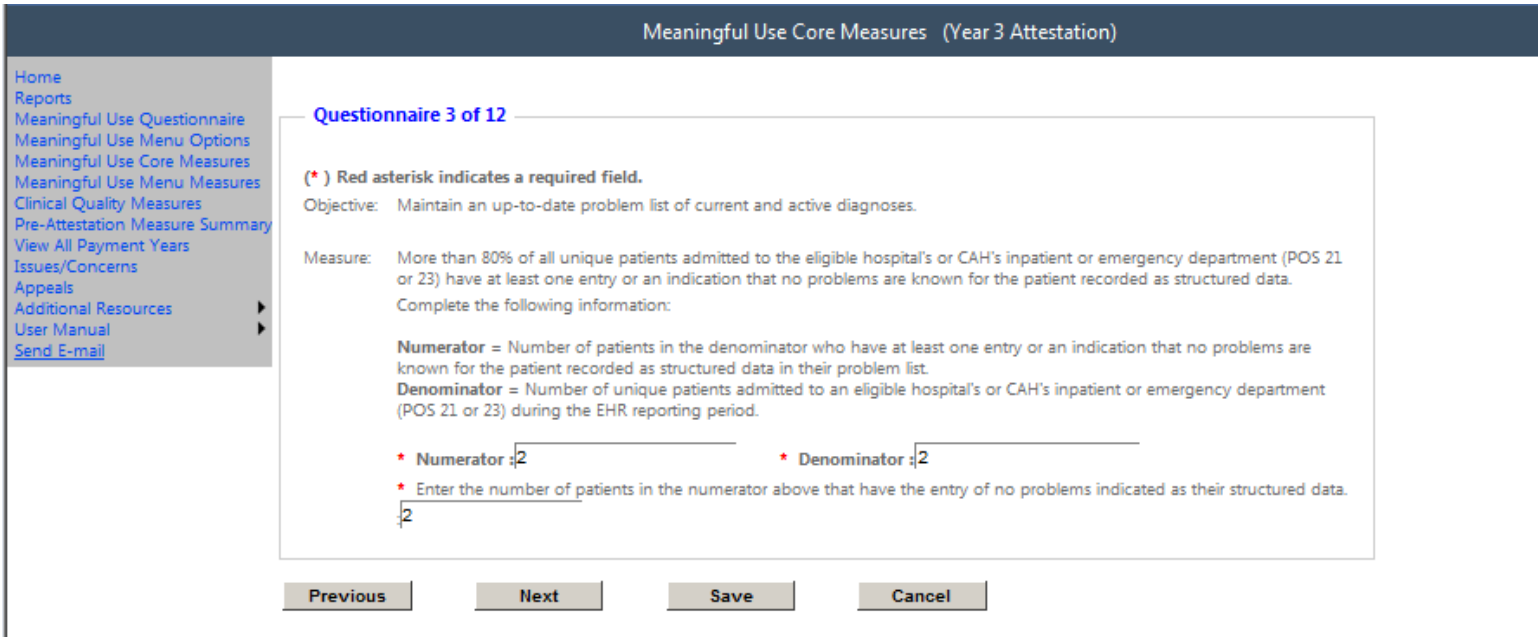


Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next' will also save data entered on the screen.

10.4 Meaningful Use Core Measure 3 Screen

Maintain Up-to-date Problem List of Current and Active Diagnoses

All fields must be completed before the EH is allowed to save and continue to the next measure.



The following details other requirements of this screen:

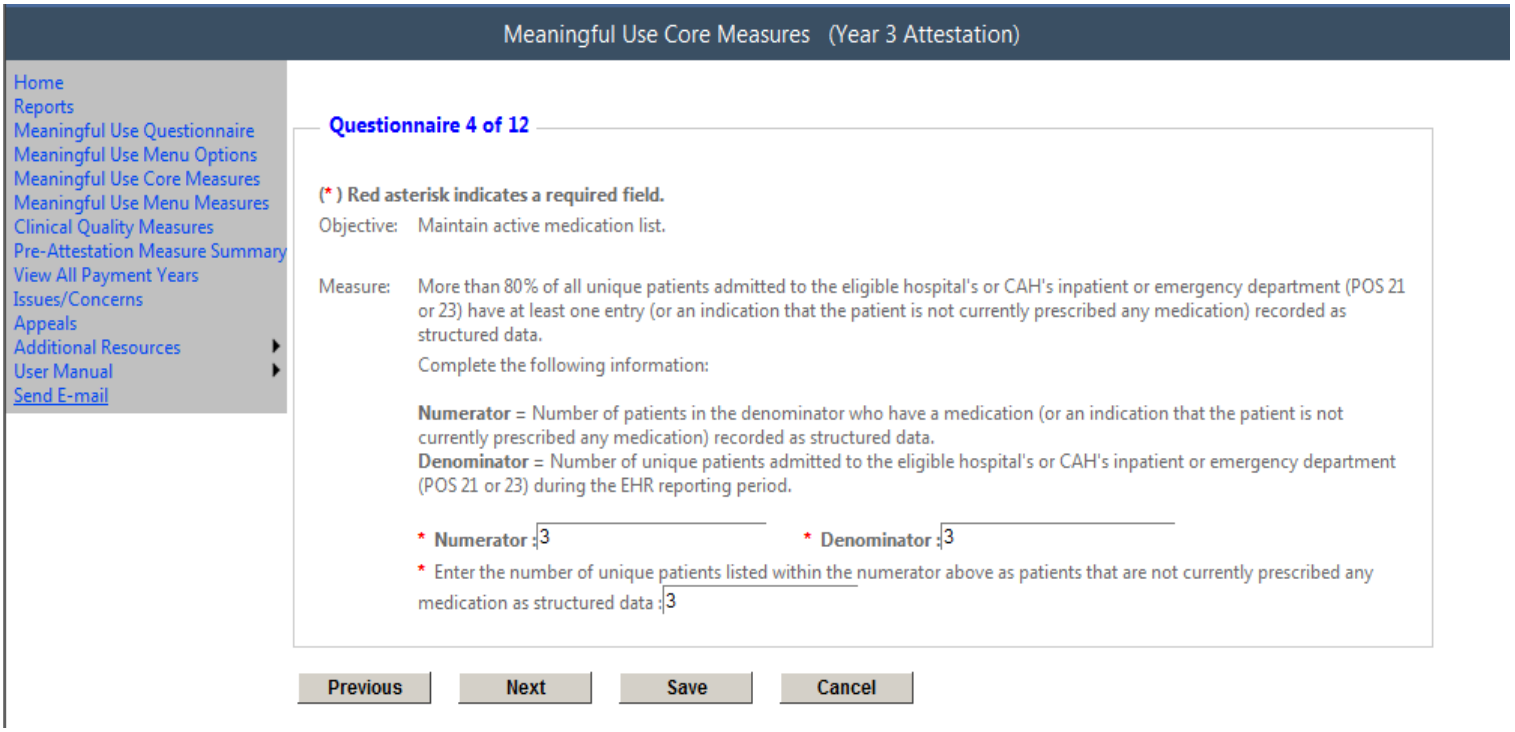
- The Numerator and Denominator are required and must be a whole number
- The Numerator should be less than or equal to the Denominator
- The EH must meet the >80% threshold, N/D > 80%
- The EH must enter an answer on the last question on the page, if the count is unknown then type unknown as the answer.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next' will also save data entered on the screen.

10.5 Meaningful Use Core Measure 4 Screen

Maintain Active Medication List

All fields must be completed before the EH is allowed to save and continue to the next measure.



The following details other requirements of this screen:

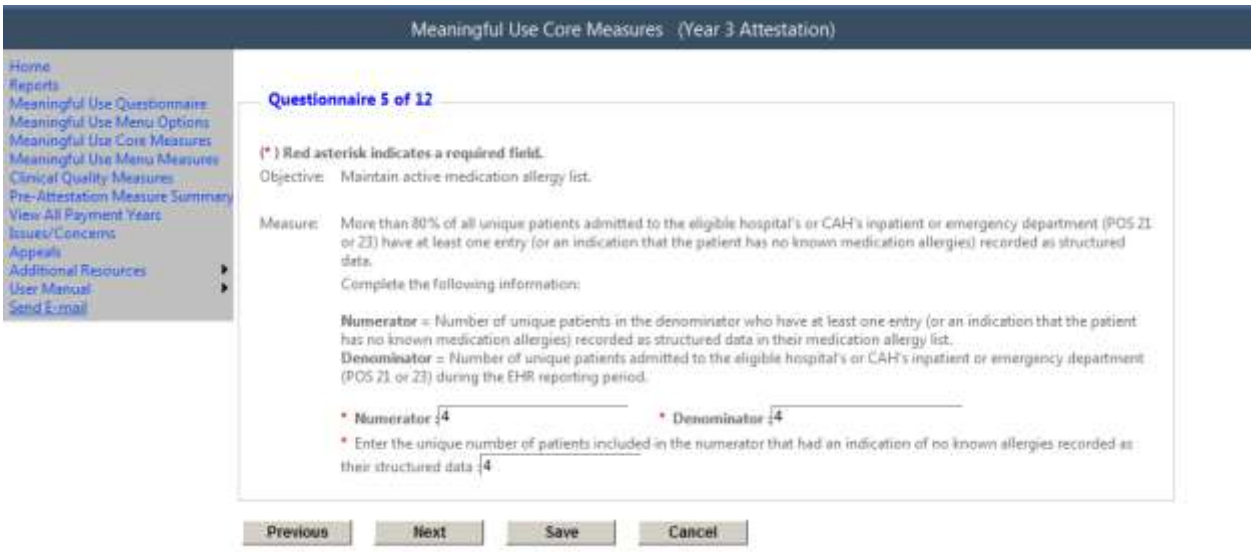
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >80% threshold, N/D > 80%.
- The EH must enter an answer on the last question on the page, if the count is unknown then type unknown as the answer

Please note that selecting 'Previous' before saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.6 Meaningful Use Core Measure 5 Screen

Maintain Active Medication Allergy List

All fields must be completed before the EH is allowed to save and continue to the next measure.



The following details other requirements of this screen:

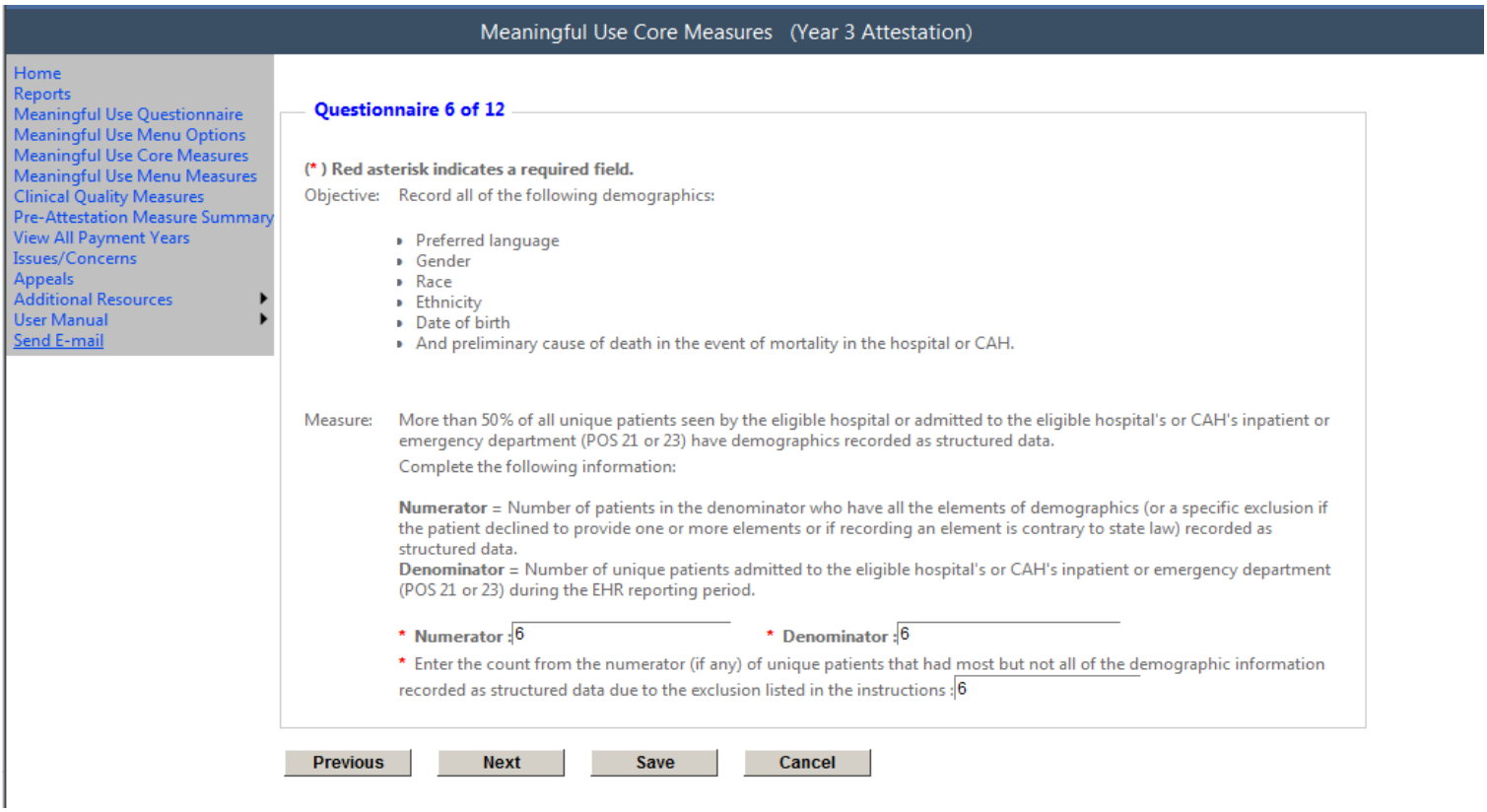
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >80% threshold, N/D > 80%.
- The EH must enter an answer on the last question on the page, if the count is unknown then type unknown as the answer.

Please note that selecting 'Previous' before saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.7 Meaningful Use Core Measure 6 Screen

Record Demographics

All fields must be completed before the EH is allowed to save and continue to the next measure.



The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.
- The EH must enter an answer on the last question on the page, if the count is unknown then type unknown as the answer.

Please note that selecting 'Previous' before saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

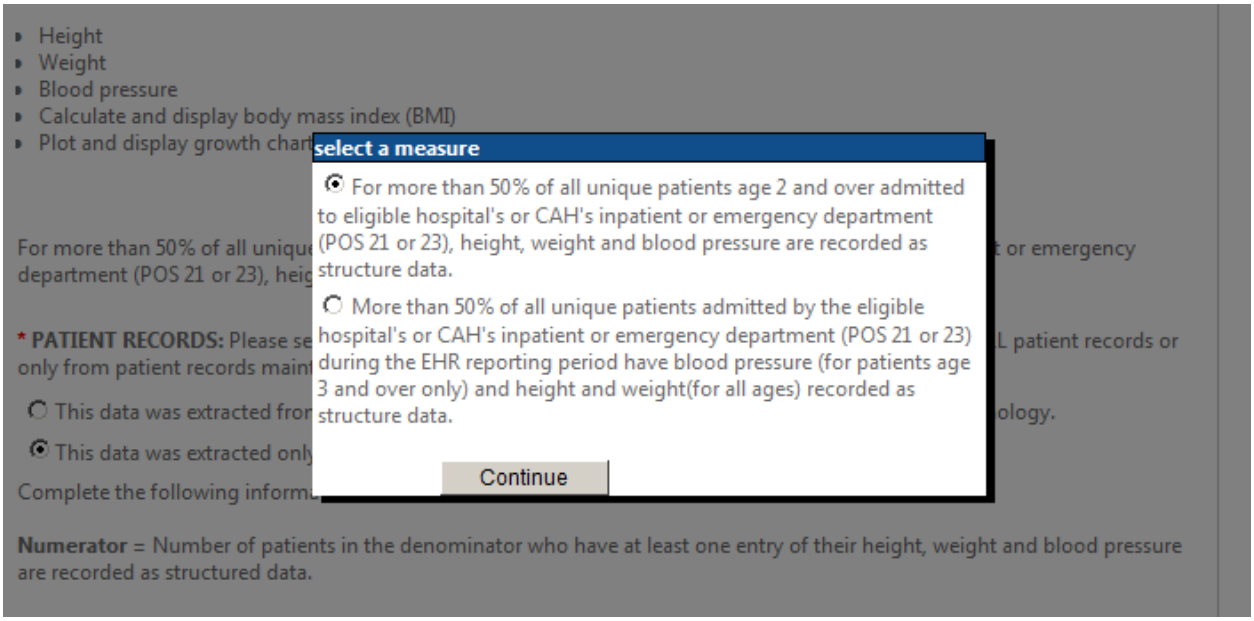
10.8 Meaningful Use Core Measure 7 Screen

Height Weight and Blood Pressure

Please select one of the following two measures:

- More than 50% of all unique patients age 2 and over seen by the EH or CAH, height, weight and blood pressure are recorded as structure data. This selection contains 2 exclusions.

- More than 50% of all unique patients seen by the EH or CAHs during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight for all ages. This selection contains 4 exclusions.

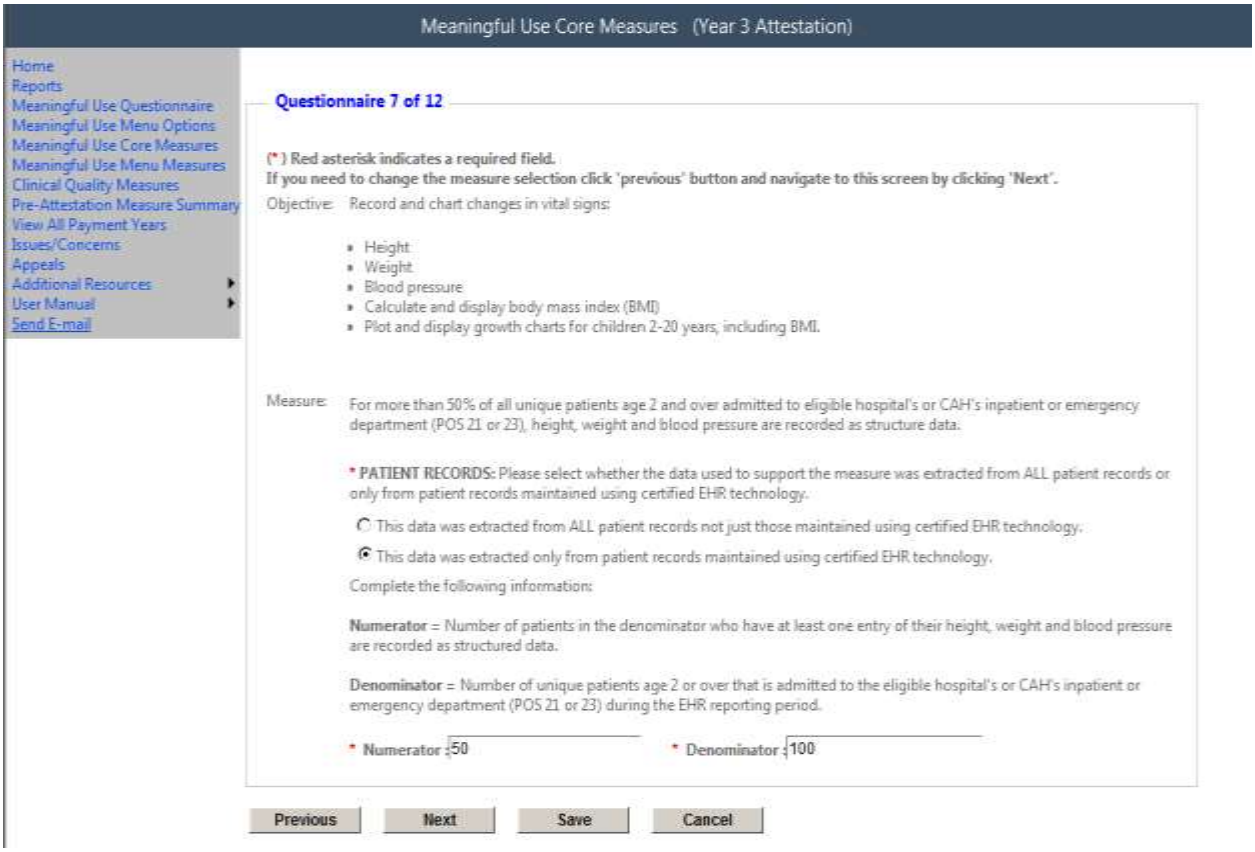


The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

10.8.1 First Alternate Measure Screen

Depending on your selection, all fields must be completed before the EH is allowed to save and continue to the next measure.



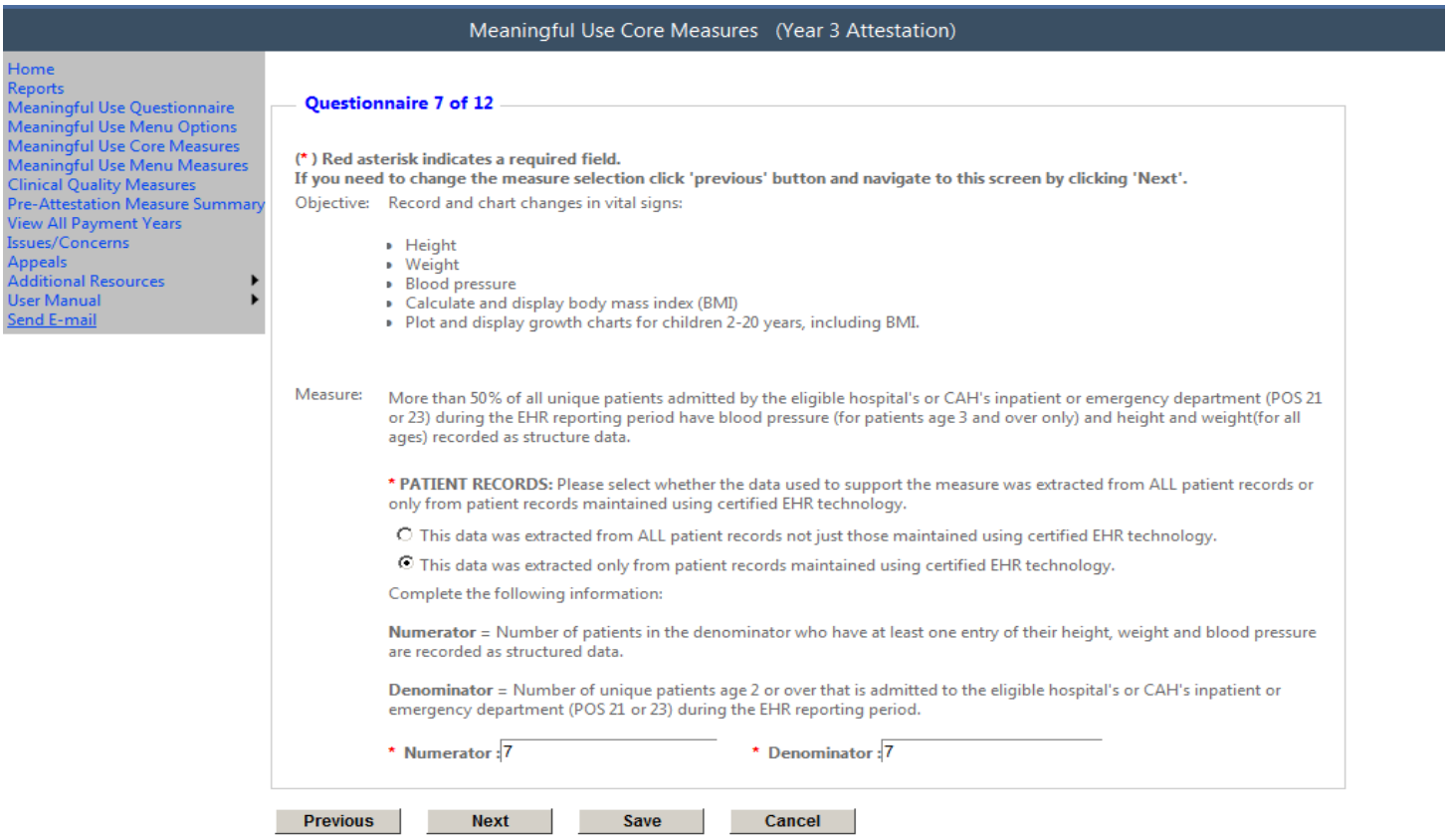
The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.8.2 Second Alternate Measure Screen

Depending on your selection, all fields must be completed before the EH is allowed to save and continue to the next measure.



The following details other requirements of this screen:

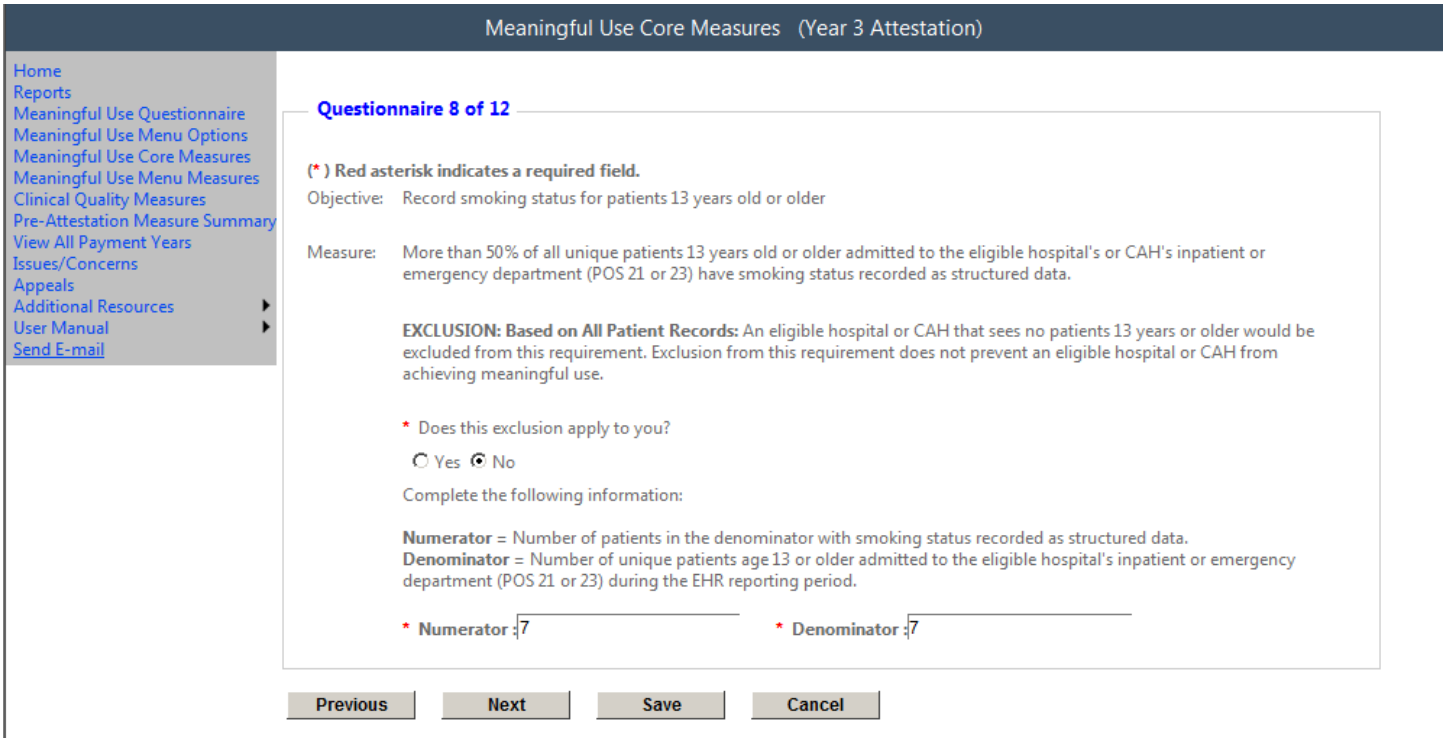
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.9 Meaningful Use Core Measure 8 Screen

Record Smoking Status

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

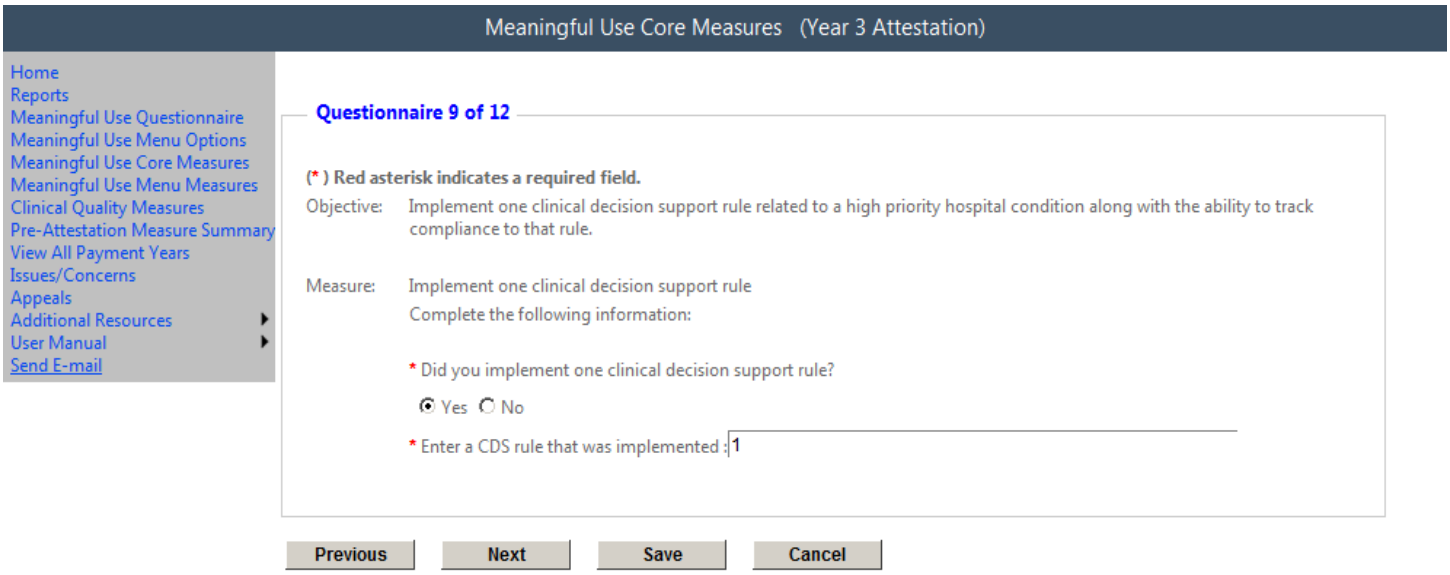
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.10 Meaningful Use Core Measure 9 Screen

Clinical Decision Support

All fields must be completed before the EH will be allowed to save and continue to the next measure.



The following details other requirements of this screen:

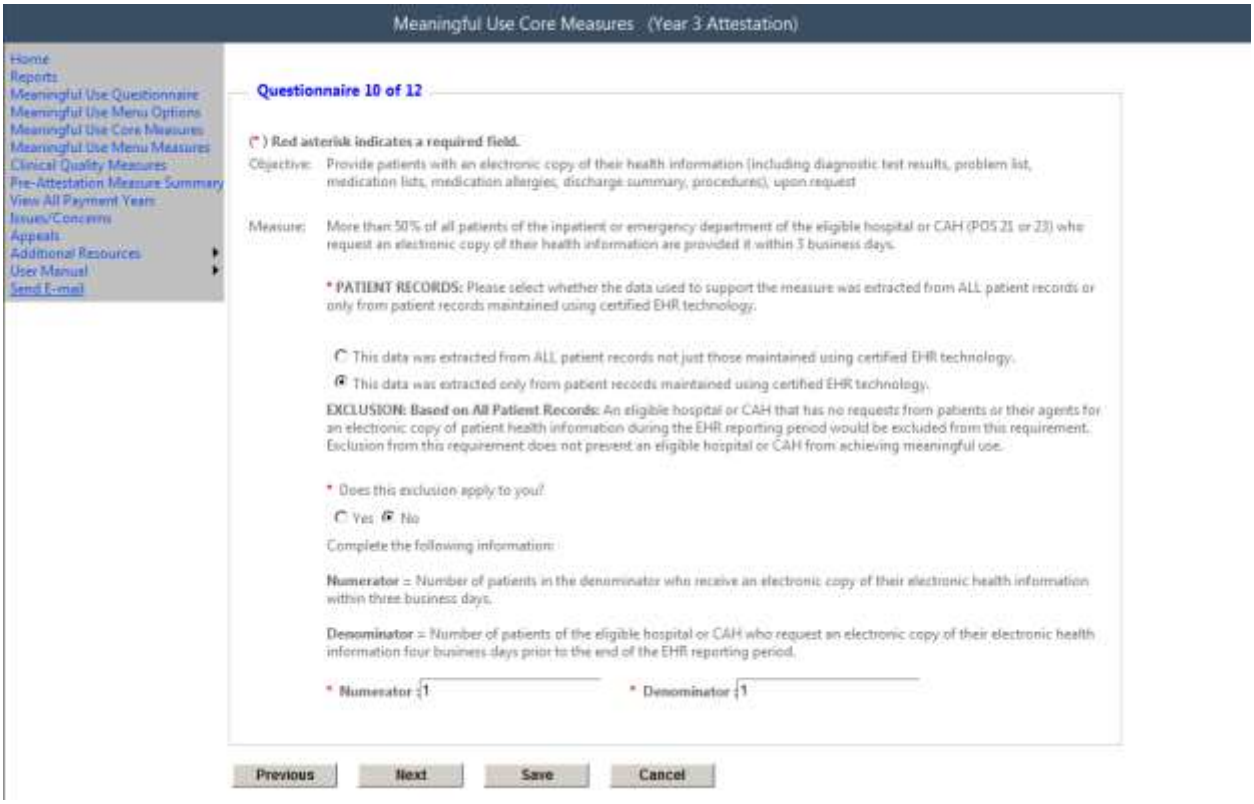
- The EH must answer yes or no to the first question on the page.
- The EH must enter the core clinical decision support rule that was implemented. If the response is unknown, then type unknown as the answer.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.11 Meaningful Use Core Measure 10 Screen

Patient Provided with a Copy of Health Information

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

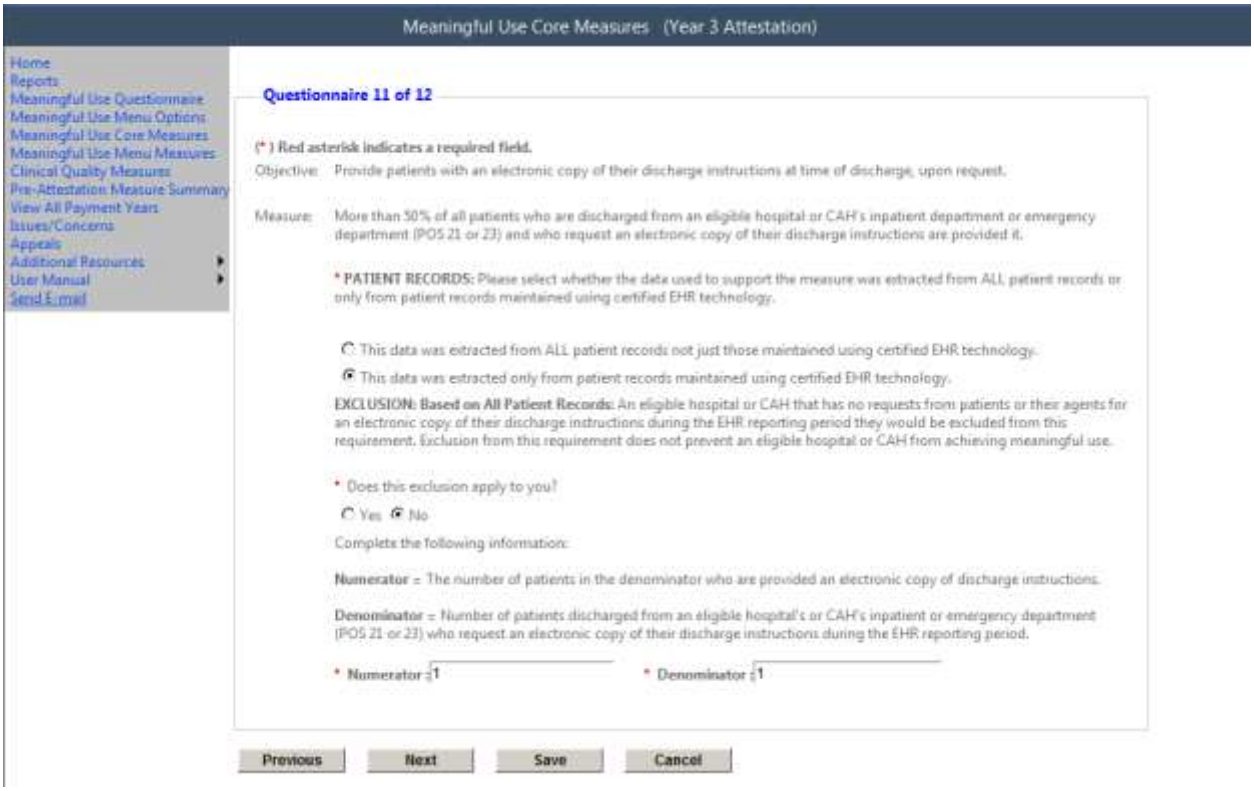
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.12 Meaningful Use Core Measure 11 Screen

Clinical Summaries for Patient

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

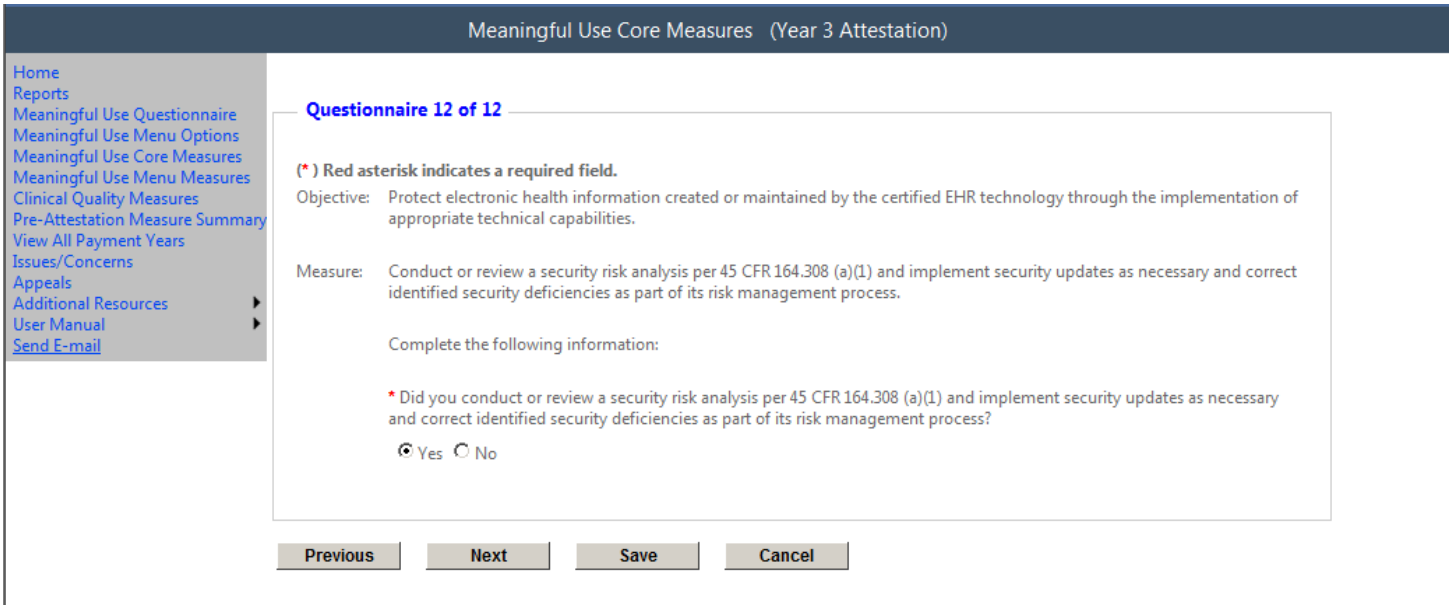
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.13 Meaningful Use Core Measure 12 Screen

Protect Electronic Health Information

All fields must be completed before the EH will be allowed to save and continue to the next measure.



The following details other requirements of this screen:

- A response must be submitted.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next' will also save data entered on the screen.

10.14 Meaningful Use Menu Measures Selection Screen

A total of 5 Menu Measures must be selected for the EH to continue to the next screen. At least one of these measures must be from the Public Health Measure list. The EH must chose a measure that they would meet unless an exclusion can be claimed for both measures. In Kentucky, the Immunization Registry, Syndromic Surveillance, Cancer Registry and Reportable Labs are available through KHIE.

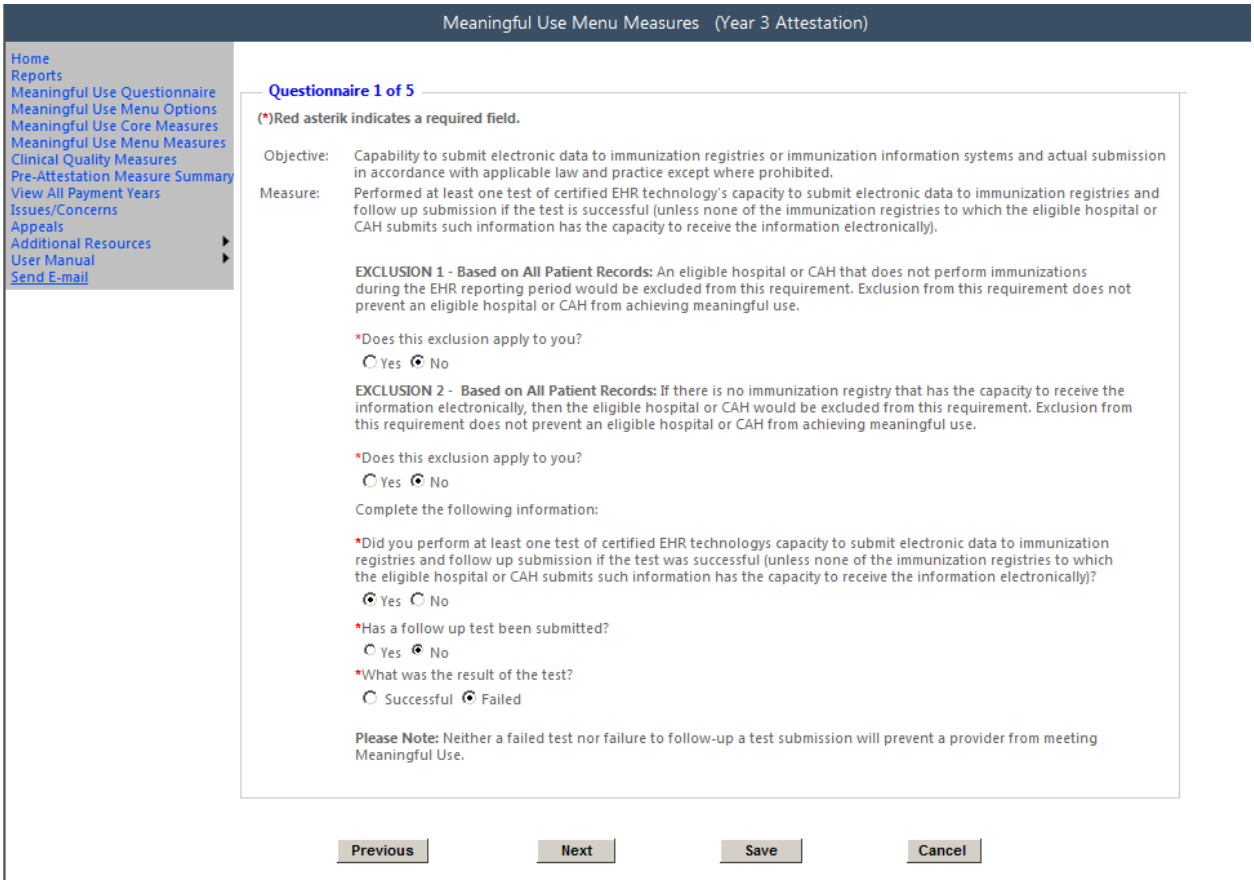
Navigation:

Logout Button – Returns the EH to the login page.
Previous button – Will not save the data selected and return the EH to the MU Core Measure 15 screen.
Next button – Will save the data to the database if no errors are present. This data will be updatable until the attestation has been completed by the EH. The EH will be directed to the first MU Menu Measure screen they selected after all errors are resolved.

10.15 Meaningful Use Menu Measure 1 Screen (Public Health)

Immunization Registry Option

All fields must be completed unless the exclusion was responded to with 'Yes', in that case no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

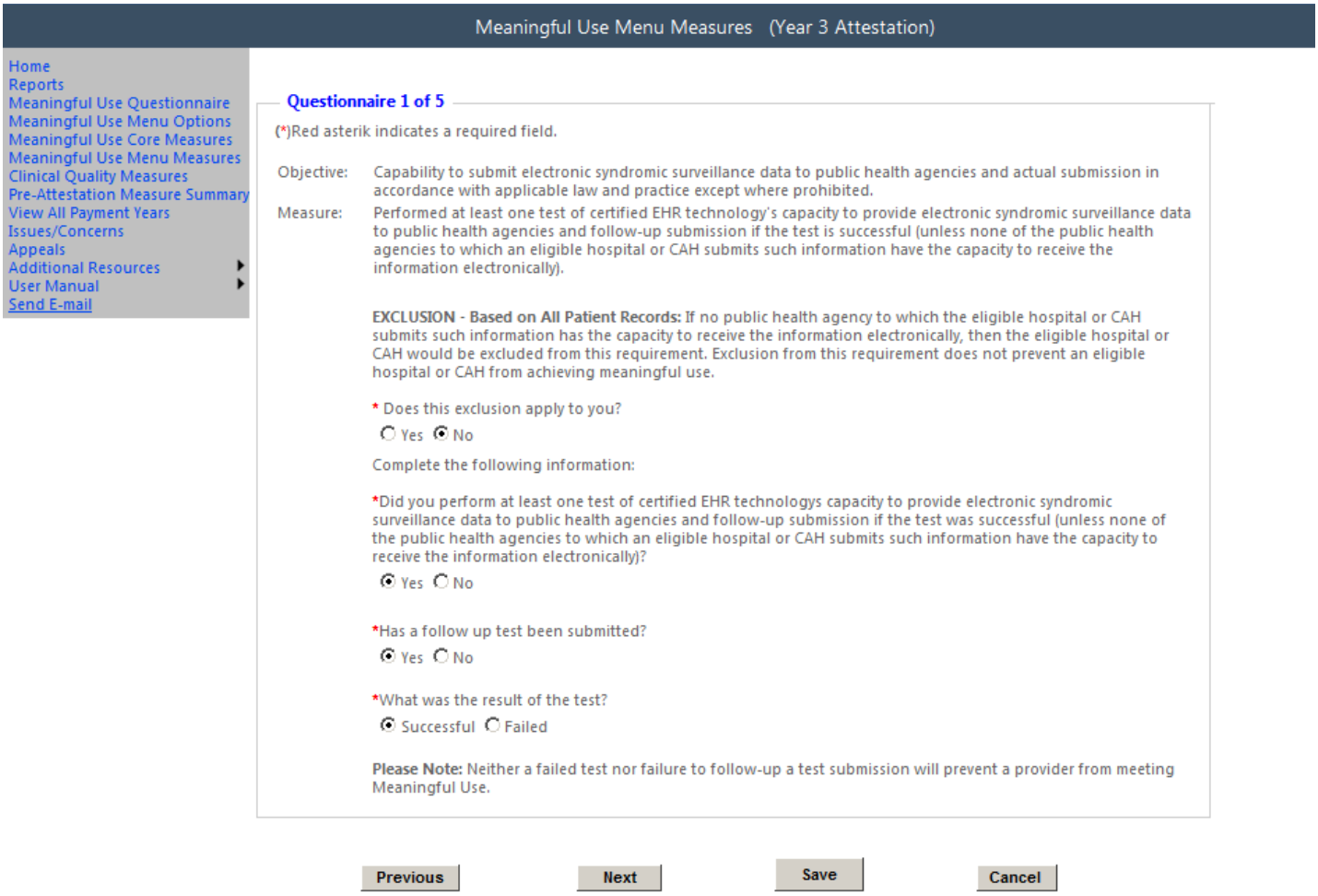
- Exclusion response is required.
- Response of yes or no is required if exclusion 1 and 2 has not been marked as yes.
- The EH must enter answers the last two questions on the page, if response is yes. Selecting that the test failed or failure to send a follow-up submission will not prevent a provider from meeting Meaningful Use.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.16 Meaningful Use Menu Measure 2 Screen (Public Health)

Syndromic Surveillance Option

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

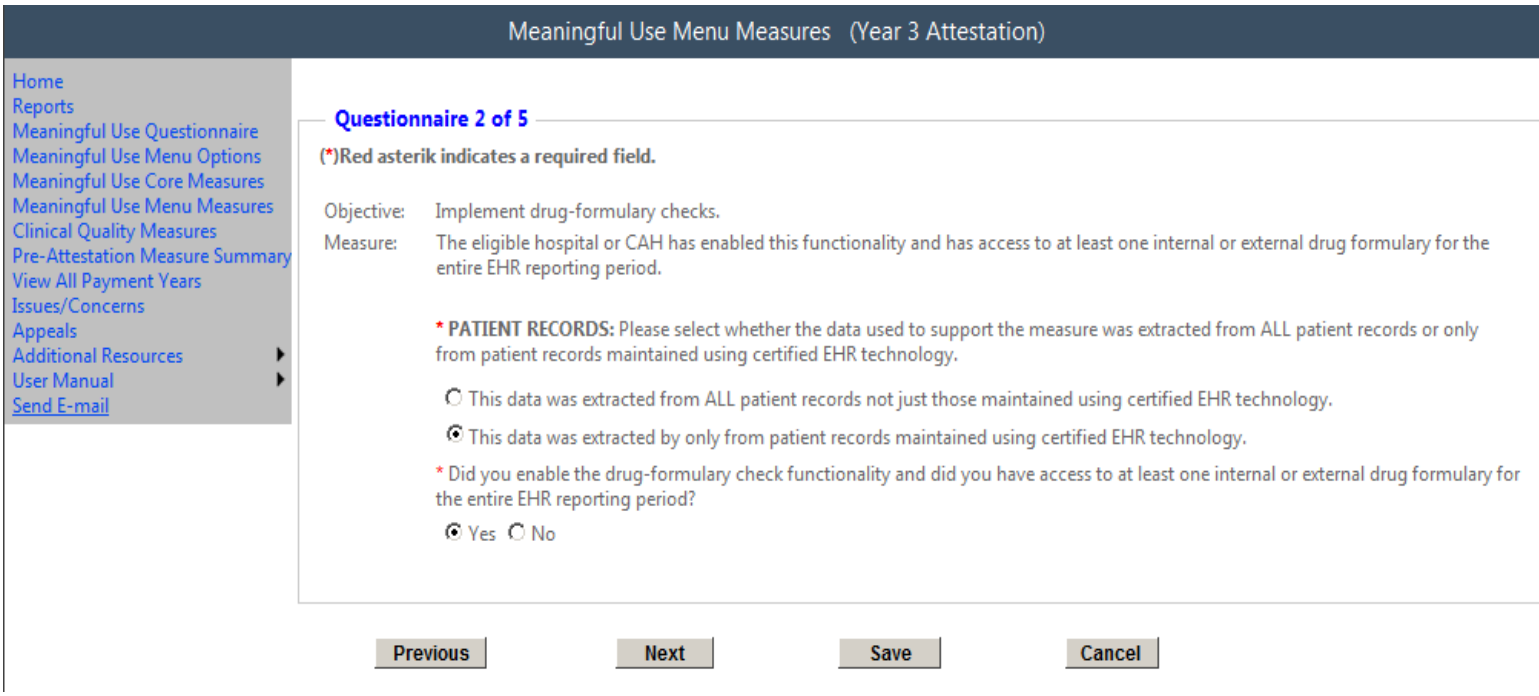
- Exclusion response required.
- Response of yes or no required if exclusion 1 and 2 has not been marked as yes.
- The EH must enter answer the last two questions on the page, if response is yes. Selecting that the test failed or failure to send a follow-up submission will not prevent a provider from meeting Meaningful Use.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next,' data entered on the screen will also be saved.

10.17 Meaningful Use Menu Measure 3 Screen

Implement Drug Formulary Checks

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

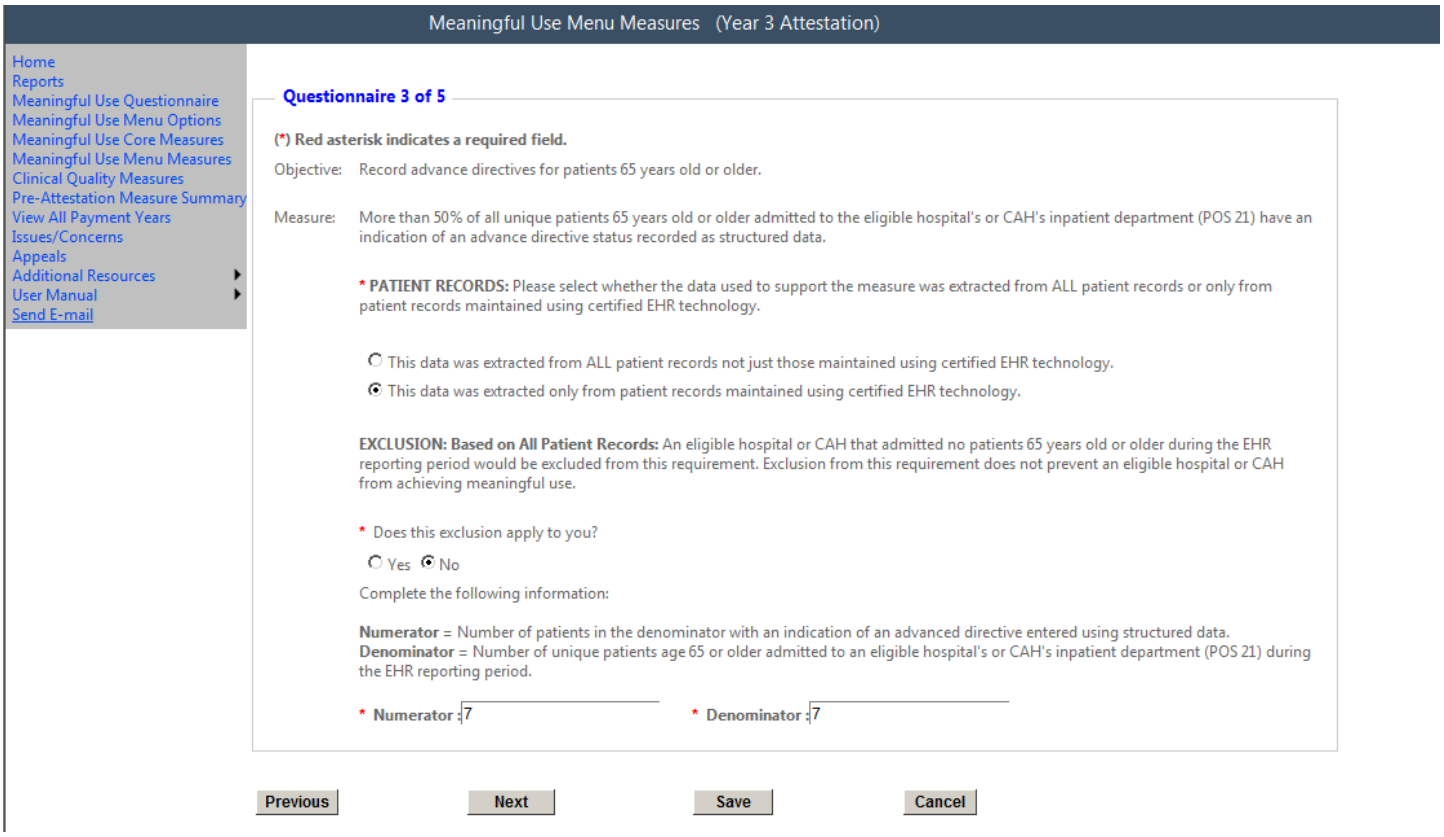
- Exclusion Response is required.
- Response to last question is required.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen is also saved.

10.18 Meaningful Use Menu Measure 4 Screen

Record Advance Directives

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

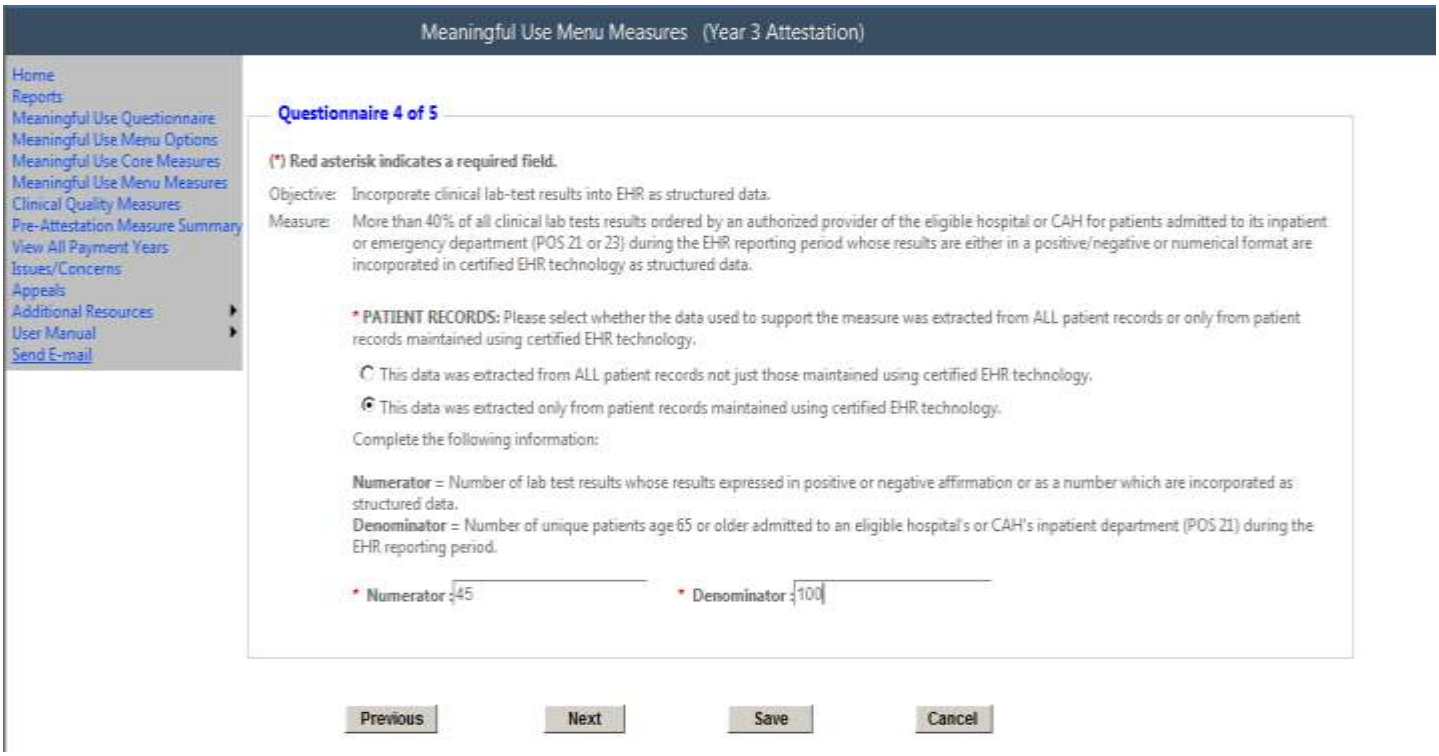
- Exclusion Response is required.
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.19 Meaningful Use Menu Measure 5 Screen

Incorporate Clinical Lab-Test Results into EHR as Structured Data

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

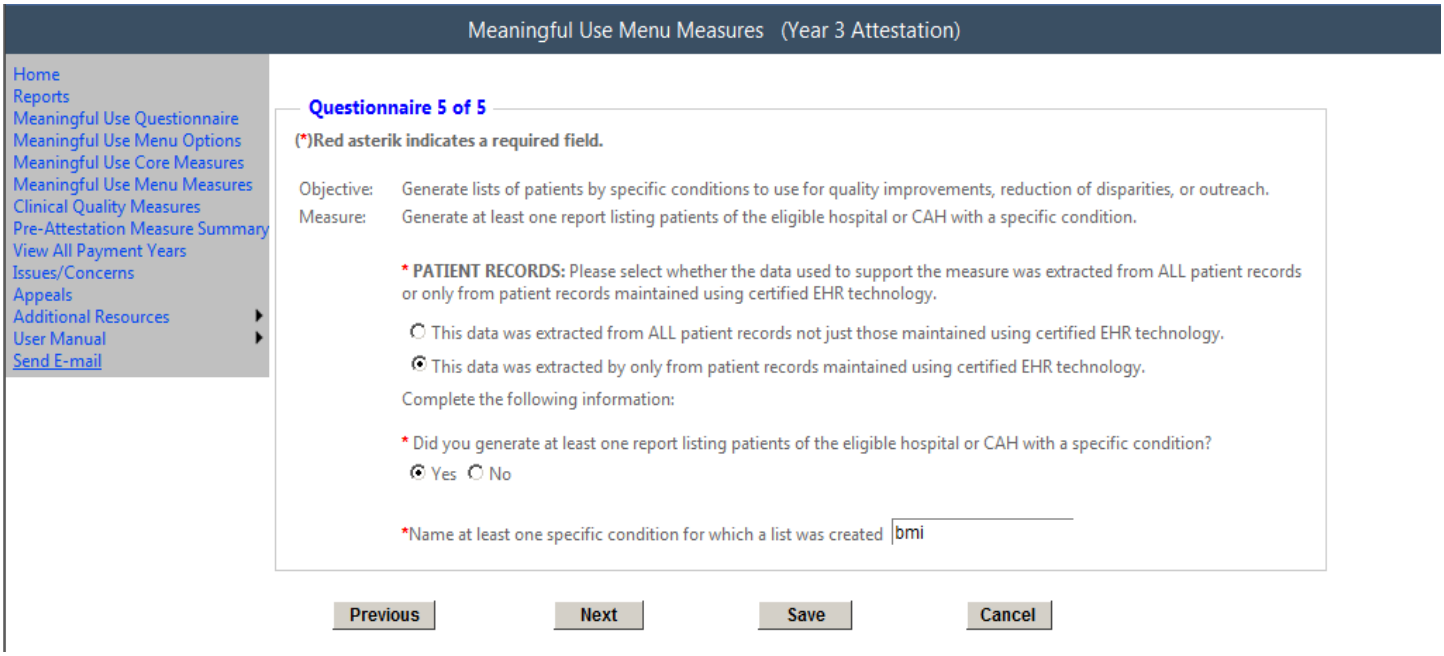
- The numerator and denominator should be a whole number.
- The numerator should be less than or equal to the denominator.
- If not excluded, the EH must meet the >40% threshold, N/D > 40%.
- If an EH responds Yes to the exclusion then they have met the measure threshold.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.20 Meaningful Use Menu Measure 6 Screen

Generate Lists of Patients by Specific Conditions

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.



The following details other requirements of this screen:

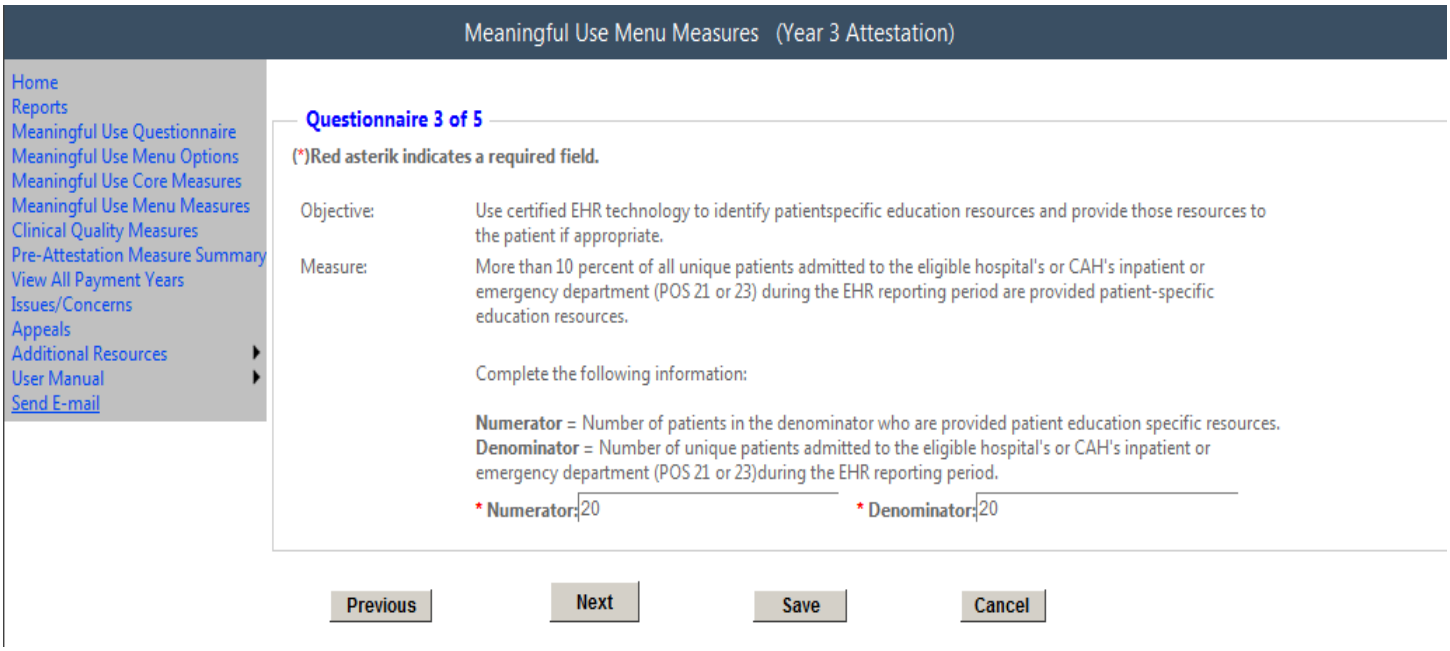
- Patient record response is required.
- Yes or No response is required.
- Response to last question is required.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.21 Meaningful Use Menu Measure 7 Screen

Use CEHRT to Identify Patient Specific Resources and Provide to Patient

All fields must be completed before the EH will be allowed to save and continue to the next measure.



The following details other requirements of this screen:

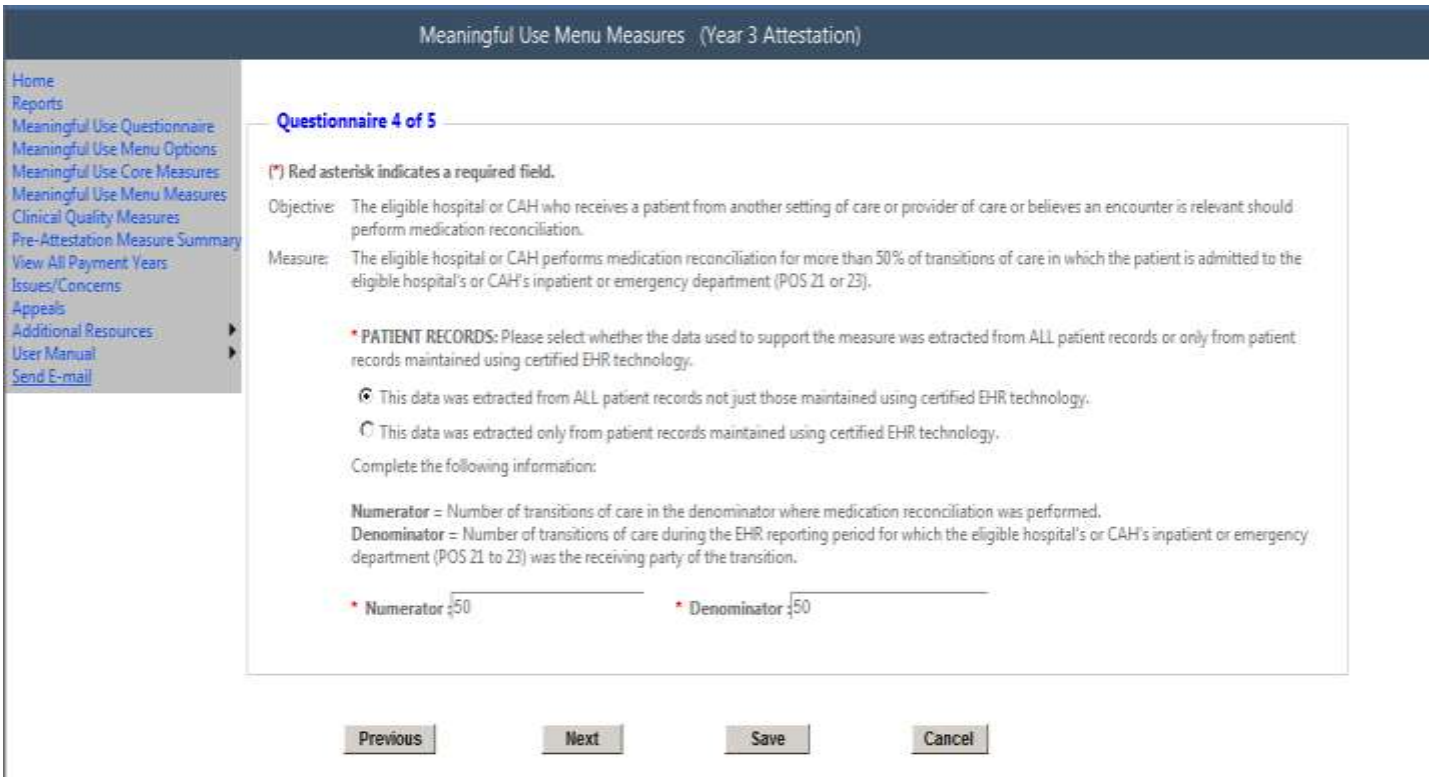
- The numerator and denominator should be a whole number.
- The numerator should be less than or equal to the denominator.
- The EH must meet the 10% threshold, N/D >10 %.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.22 Meaningful Use Menu Measure 8 Screen

Receiving EH/CAH should perform Medication Reconciliation

All fields must be completed before the EH will be allowed to save and continue to the next measure.



The following details other requirements of this screen:

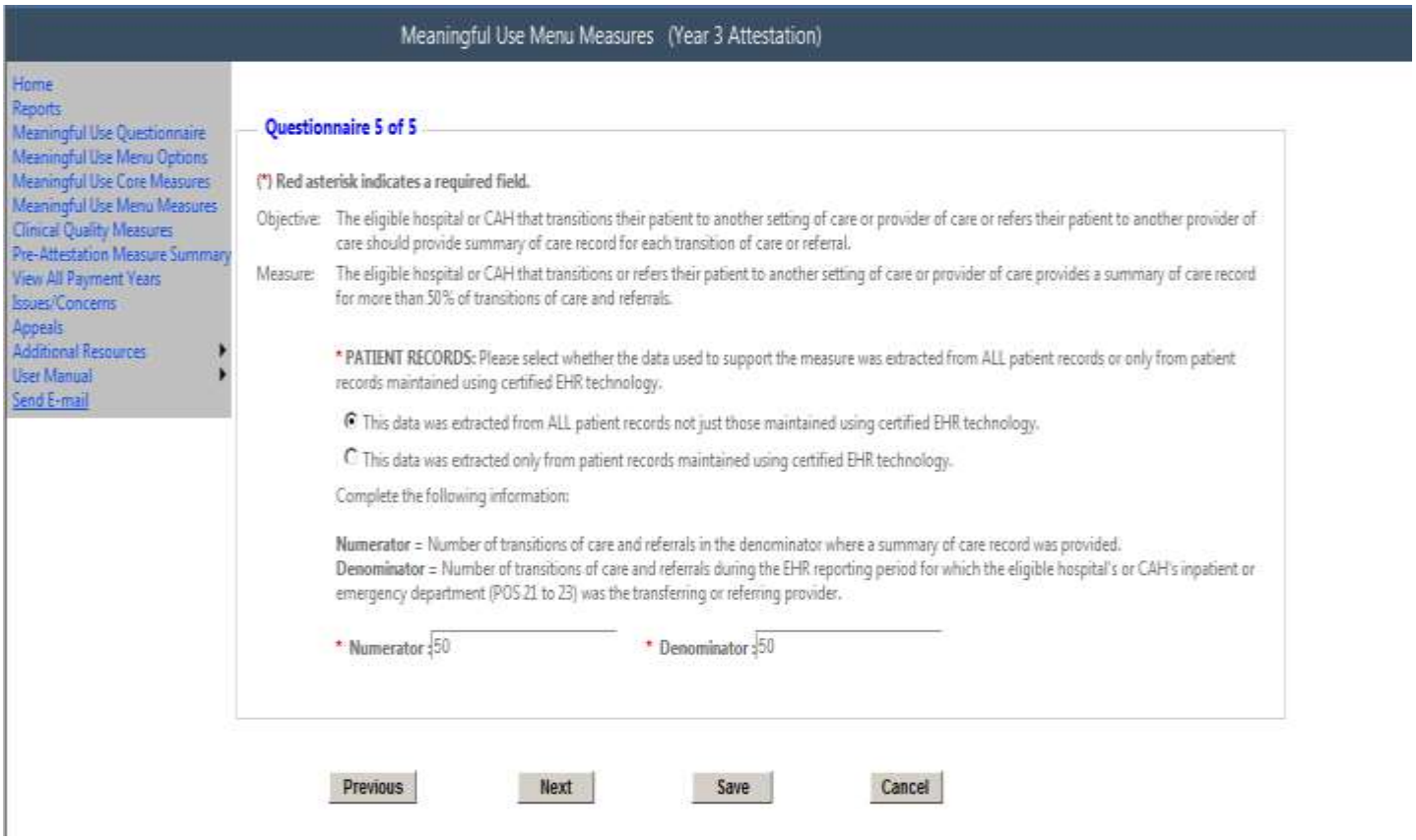
- The numerator and denominator should be a whole number.
- The numerator should be less than or equal to the denominator.
- EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.23 Meaningful Use Menu Measure 9 Screen

Providing Summary of Care for each Transition or Referral

All fields must be completed before the EH will be allowed to save and continue to the next measure.



The following details other requirements of this screen:

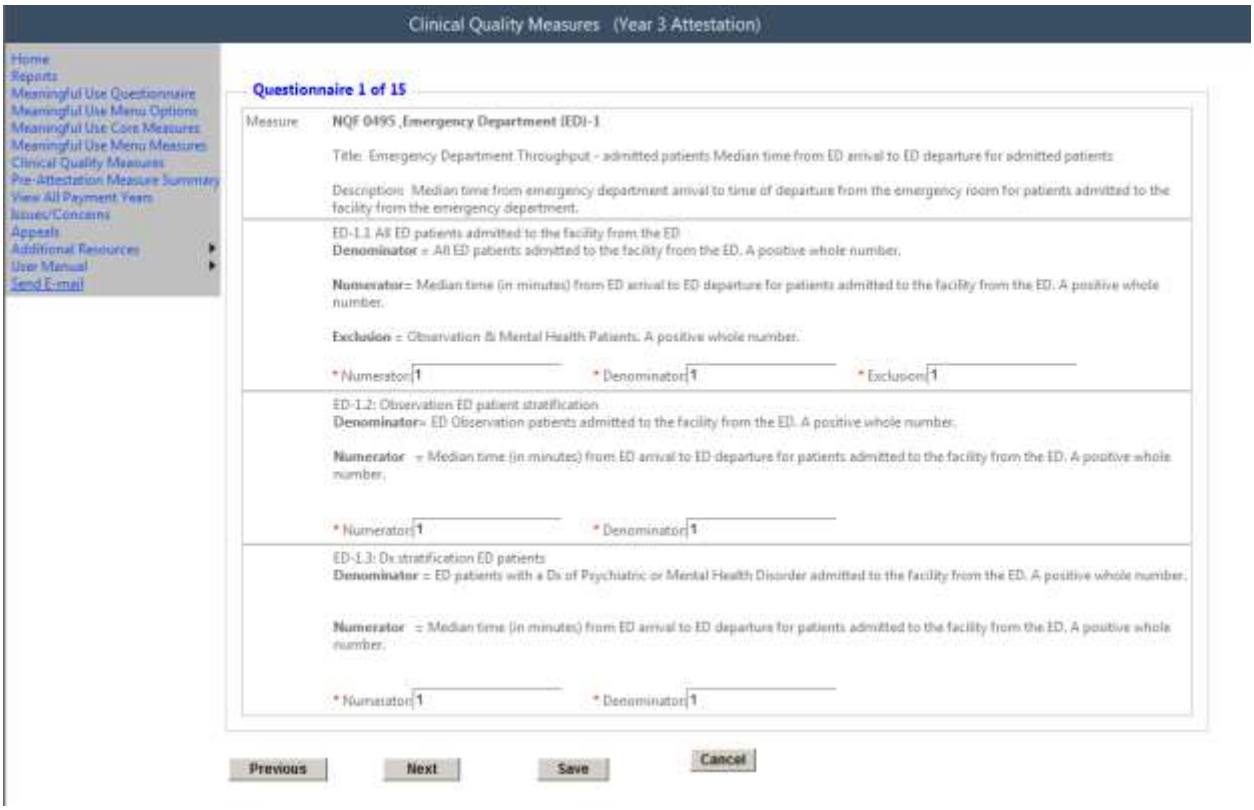
- The numerator and denominator should be a whole number.
- The numerator should be less than or equal to the denominator.
- EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.24 Core Clinical Quality Measure 1 Screen

Emergency Department Throughput - admitted patients Median time from ED arrival to ED departure for admitted patients

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

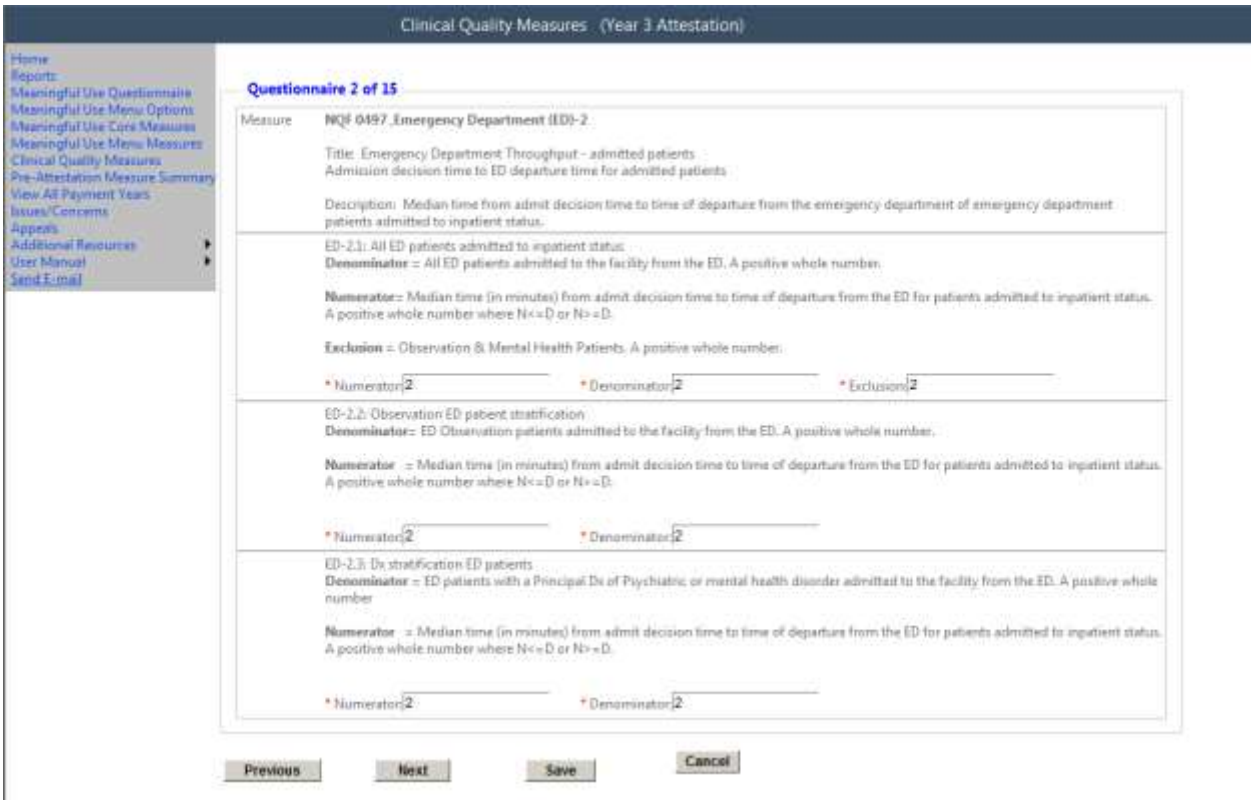
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.25 Core Clinical Quality Measure 2 Screen

Emergency Department Throughput - admitted patients Admission decision time to ED departure time for admitted patients

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

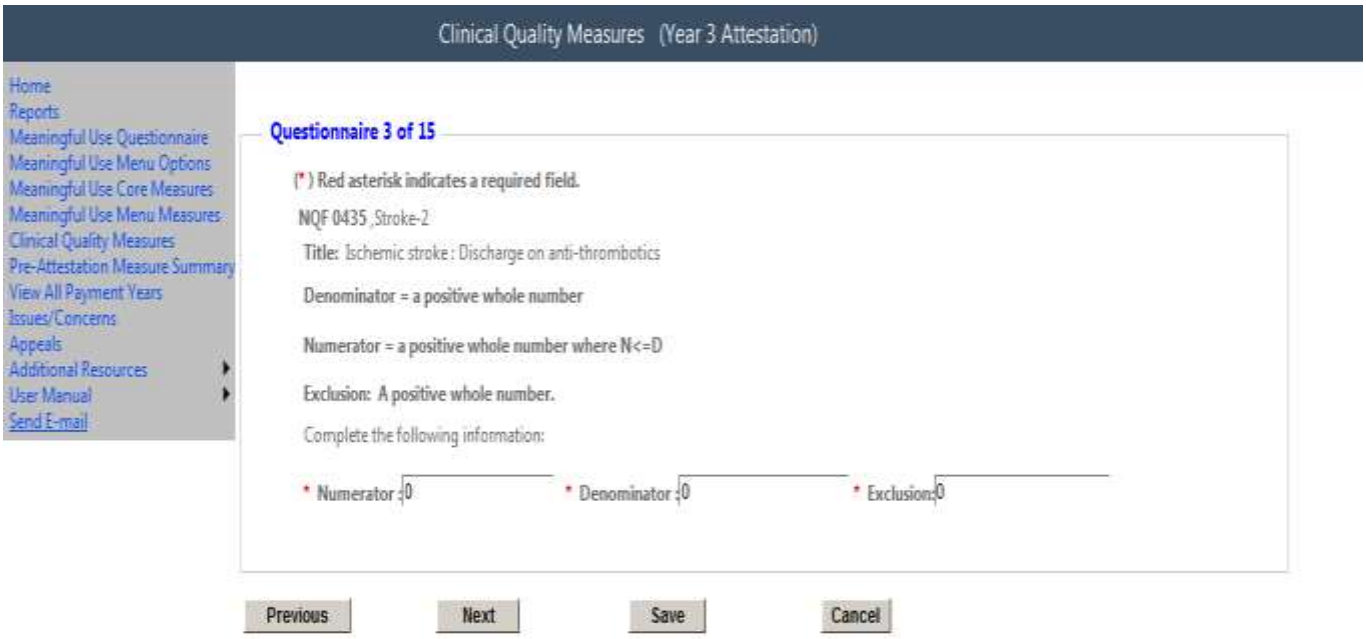
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.26 Core Clinical Quality Measure 3 Screen

Ischemic stroke : Discharge on anti-thrombotics

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

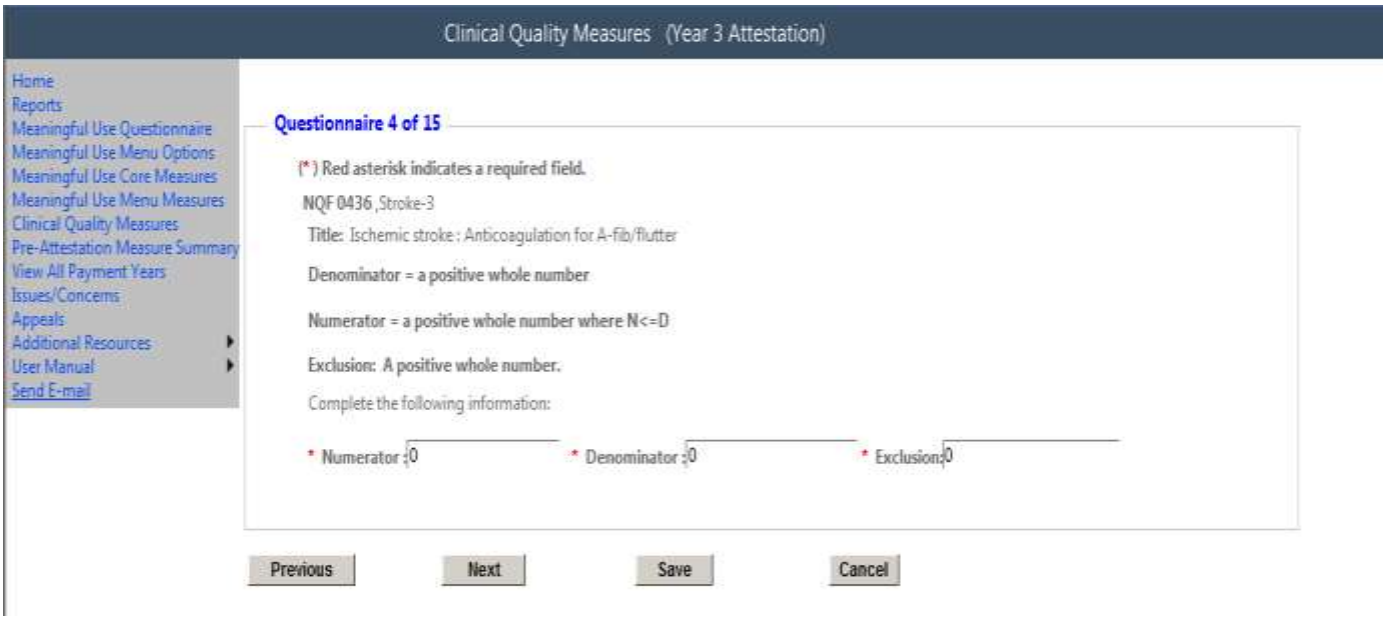
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.27 Clinical Core Quality Measure 4 Screen

Ischemic stroke : Anticoagulation for A-fib/flutter

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

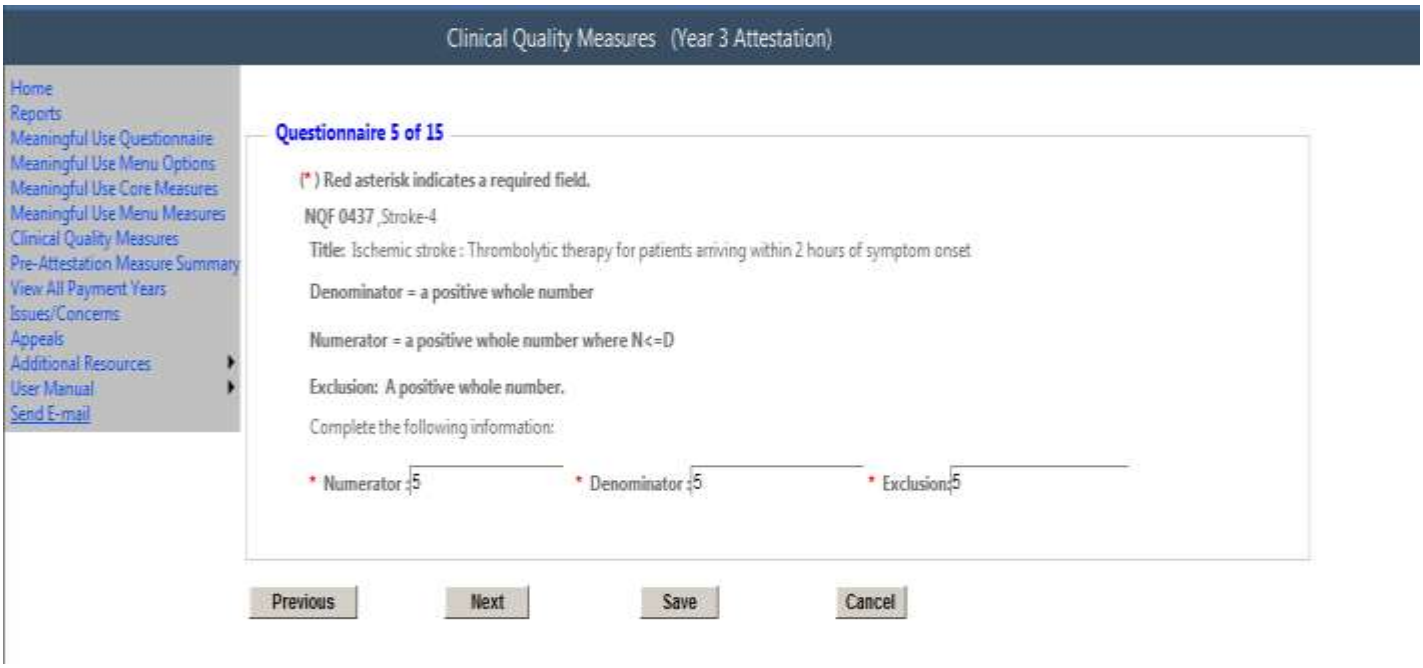
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.28 Core Clinical Quality Measure 5 Screen

Ischemic stroke : Thrombolytic therapy for patients arriving within 2 hours of symptom onset

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

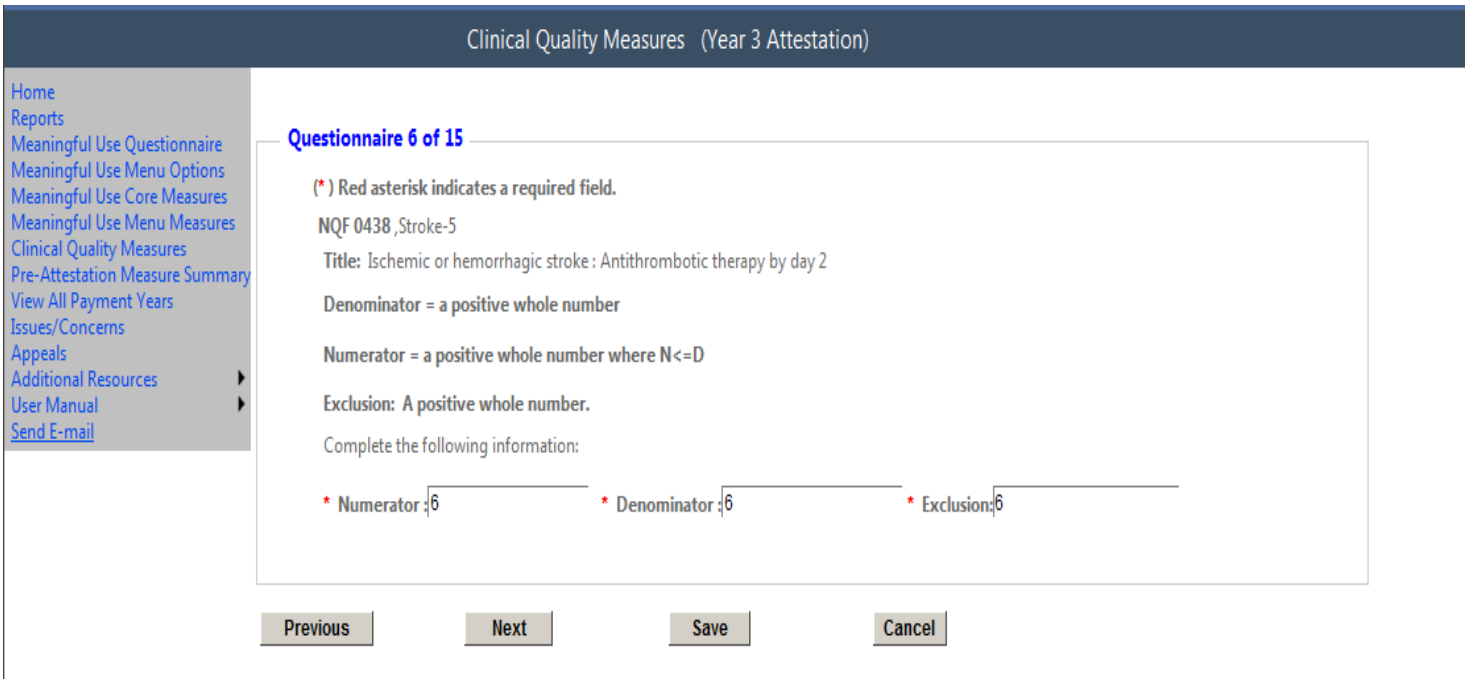
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.29 Core Clinical Quality Measure 6 Screen

Ischemic or hemorrhagic stroke : Antithrombotic therapy by day 2

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

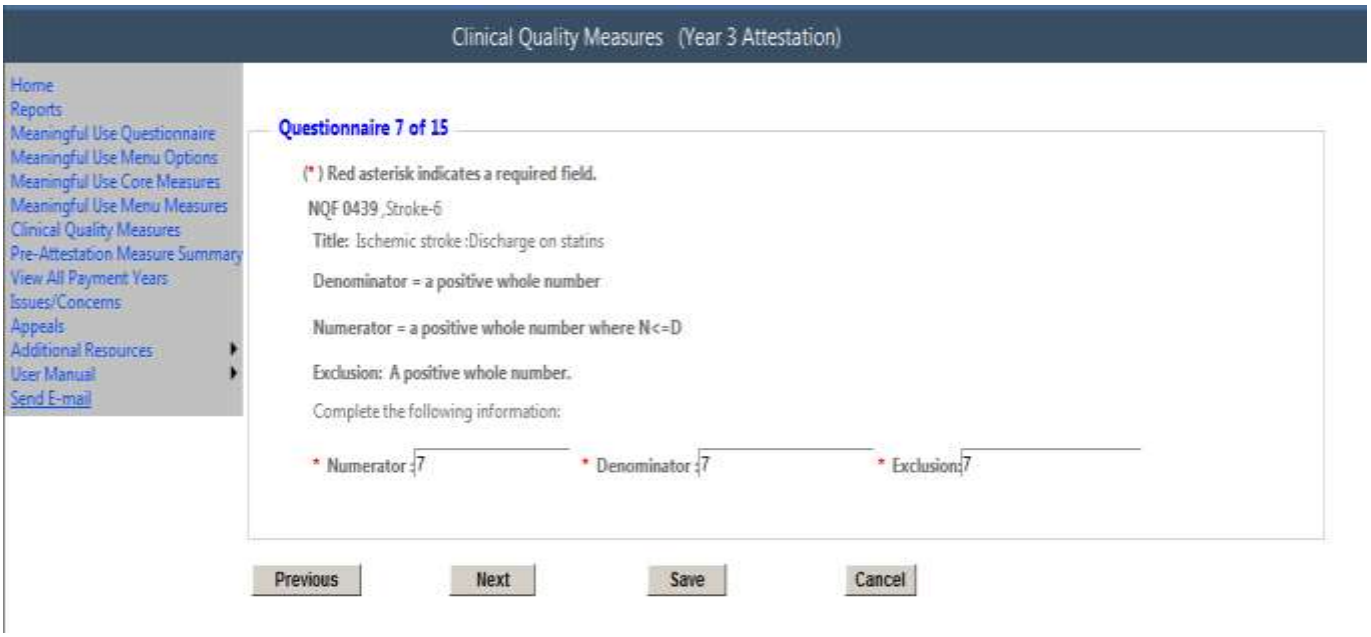
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.30 Core Clinical Quality Measure 7 Screen

Ischemic stroke :Discharge on statins

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

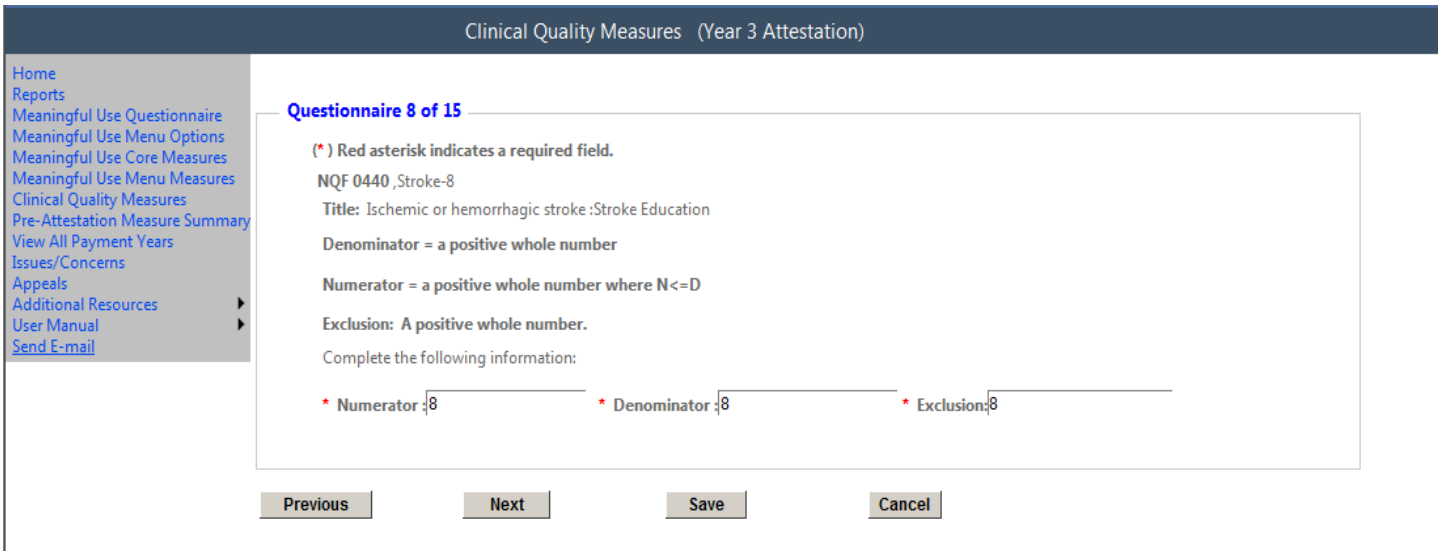
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.31 Core Clinical Quality Measure 8 Screen

Ischemic or hemorrhagic stroke :Stroke Education

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

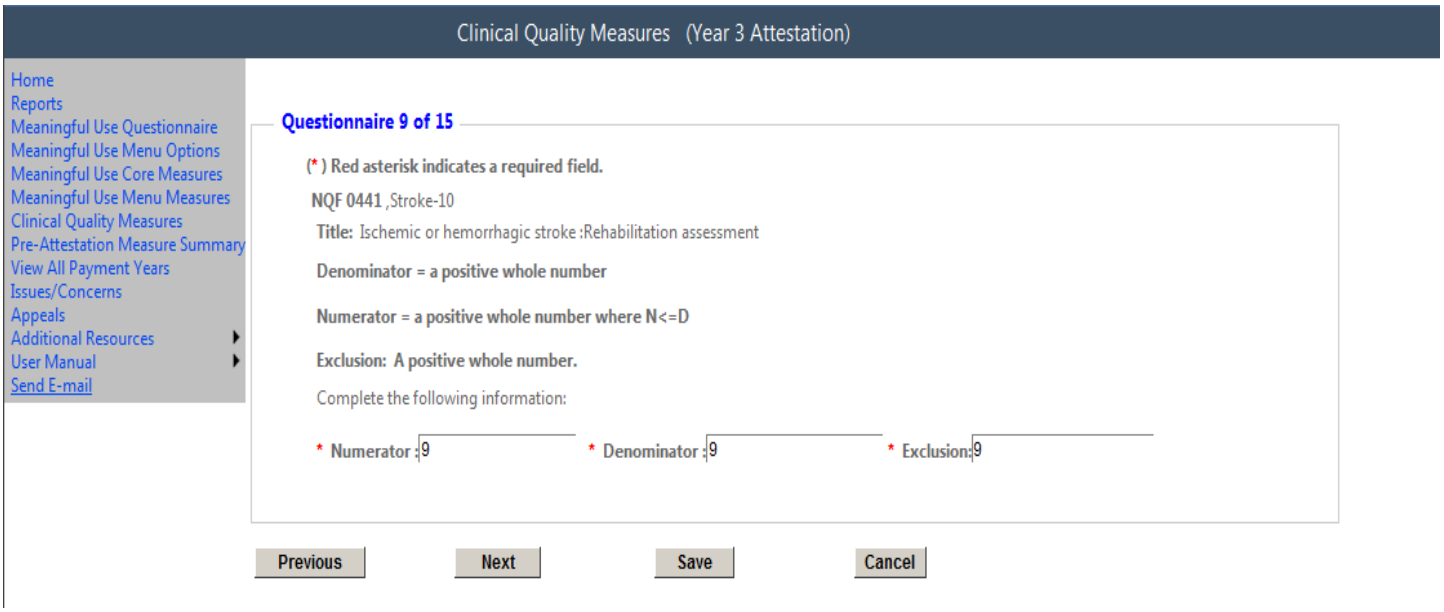
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.32 Core Clinical Quality Measure 9 Screen

Ischemic or hemorrhagic stroke: Rehabilitation assessment

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

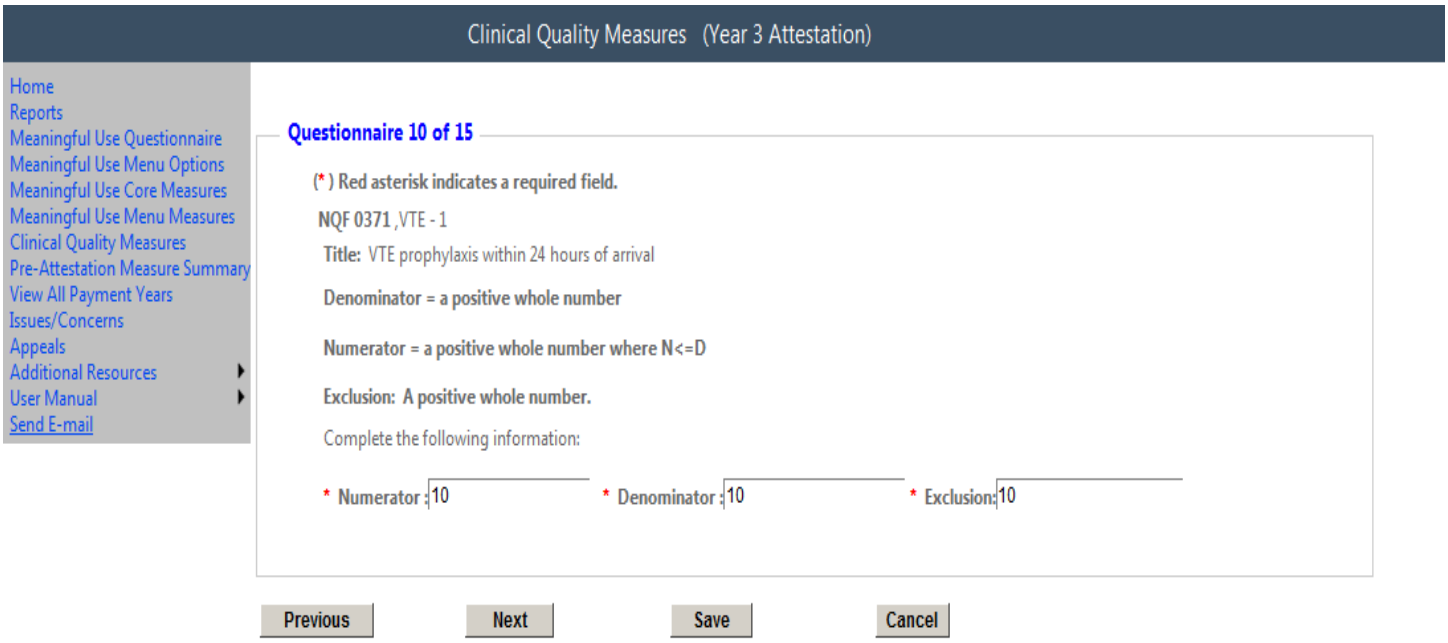
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.33 Core Clinical Quality Measure 10 Screen

VTE prophylaxis within 24 hours of arrival

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

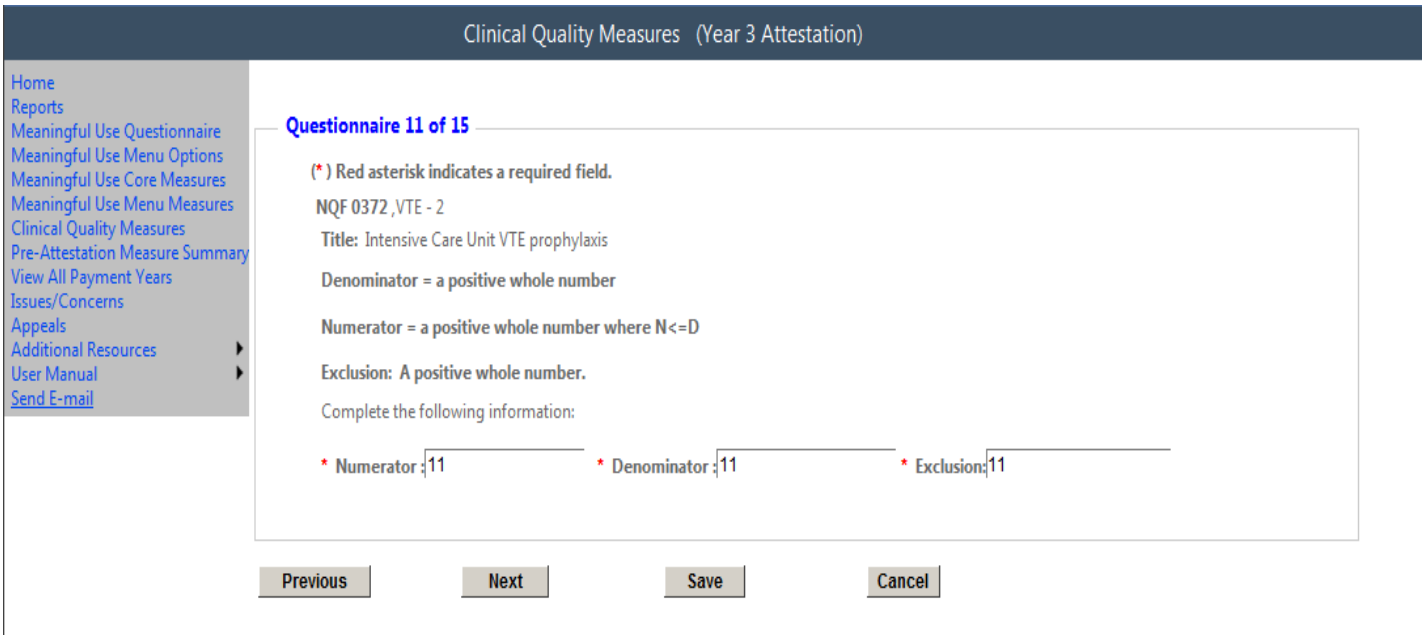
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.34 Core Clinical Quality Measure 11 Screen

Intensive Care Unit VTE prophylaxis

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

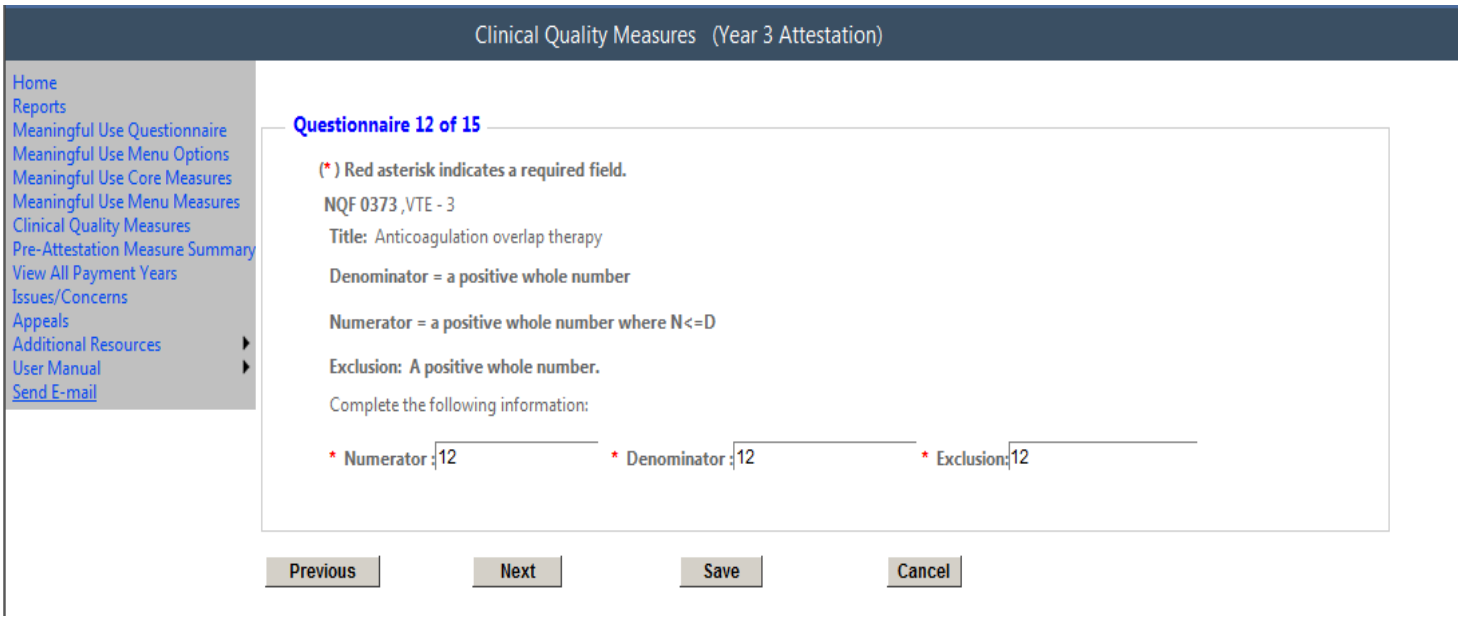
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

10.35 Core Clinical Quality Measure 12 Screen

Anticoagulation overlap therapy

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

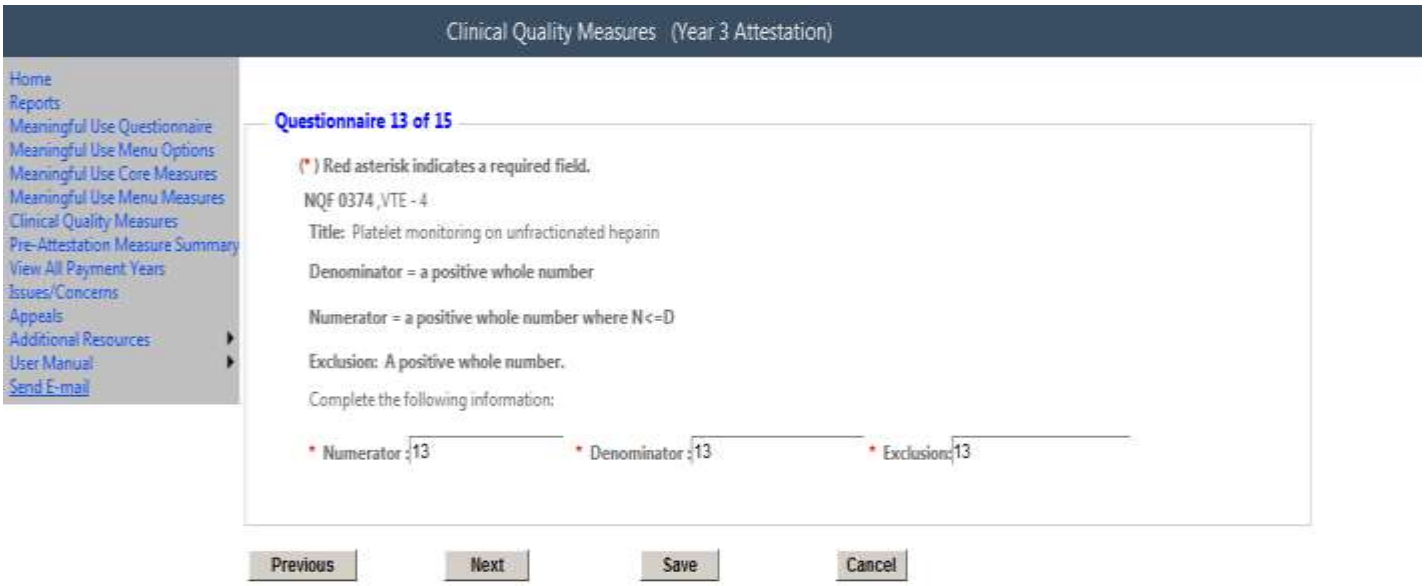
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.36 Core Clinical Quality Measure 13 Screen

Platelet monitoring on unfractionated heparin

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

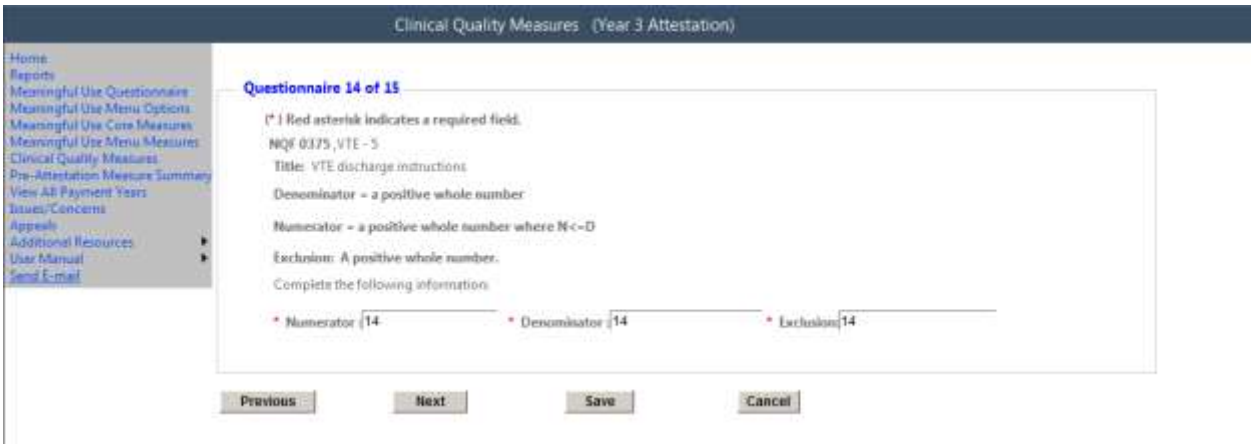
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.37 Core Clinical Quality Measure 14 Screen

VTE discharge instructions

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

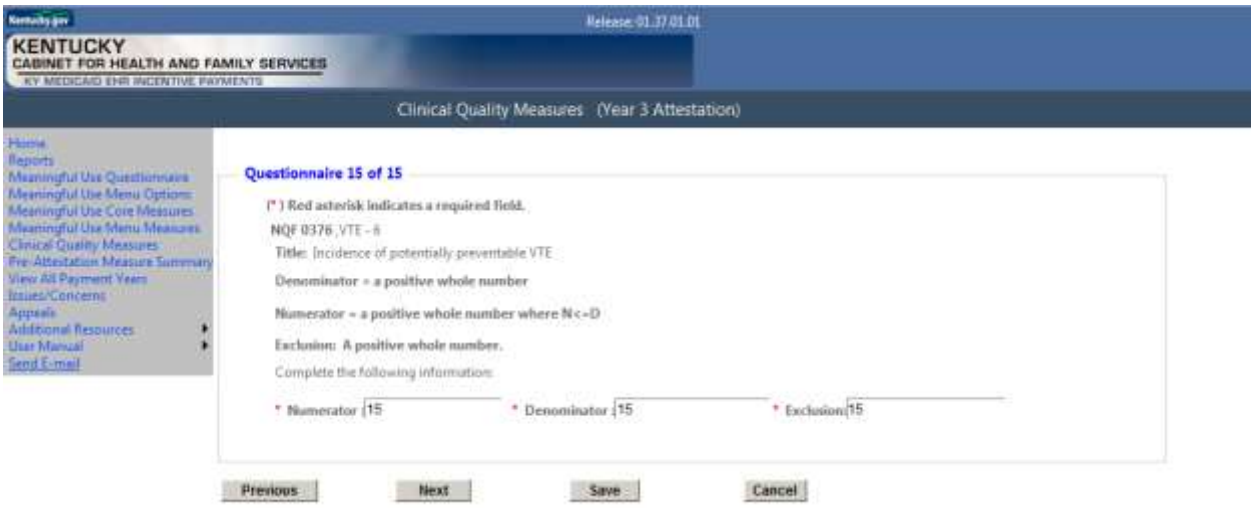
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.38 Core Clinical Quality Measure 15 Screen

Incidence of potentially preventable VTE

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.



The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

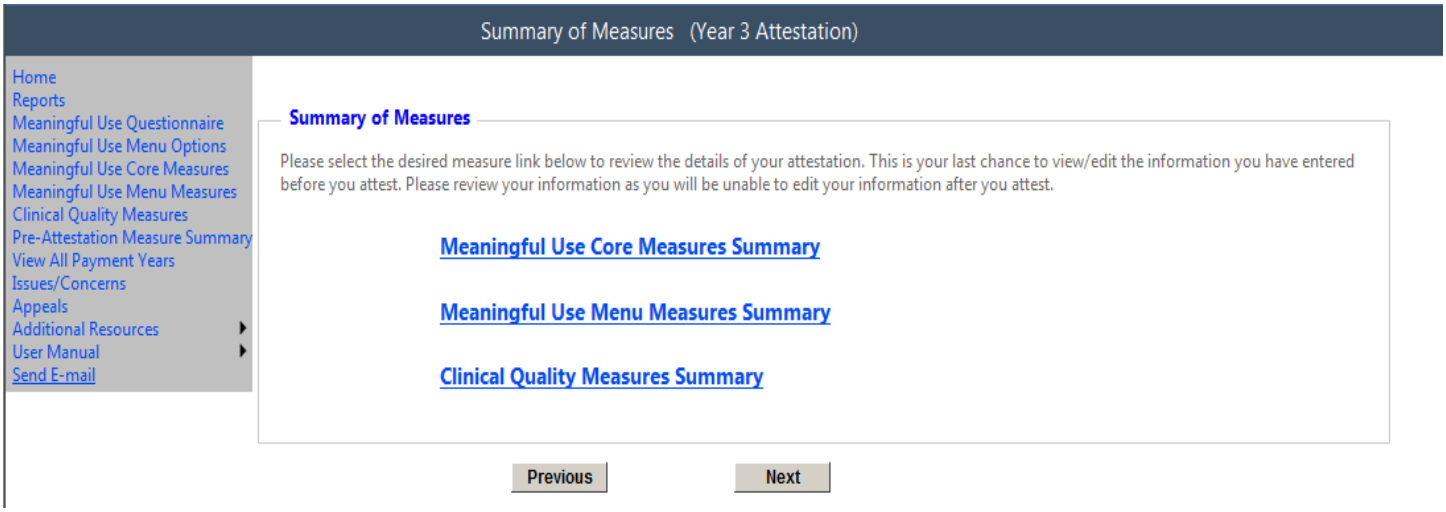
Please note that selecting ‘Previous’ prior to saving will result in the data on the current screen not being saved. If the user clicks on ‘Next’, data entered on the screen will also be saved.

10.39 Meaningful Use Summary of Measure Screen

Meaningful Use Core Measures Summary – Takes the EH to a summary screen of their entries for the Core MU measures. This screen will allow them to edit any entry they have made prior to continuing with their attestation.

Meaningful Use Menu Measures Summary – Takes the EH to a summary screen of their entries for the Menu MU measures. This screen will allow them to edit any entry they have made prior to continuing with their attestation.

Clinical Quality Measures Summary – Takes the EH to a summary screen of their entries for the Clinical Quality measures. This screen will allow them to edit any entry they have made prior to continuing with their attestation.

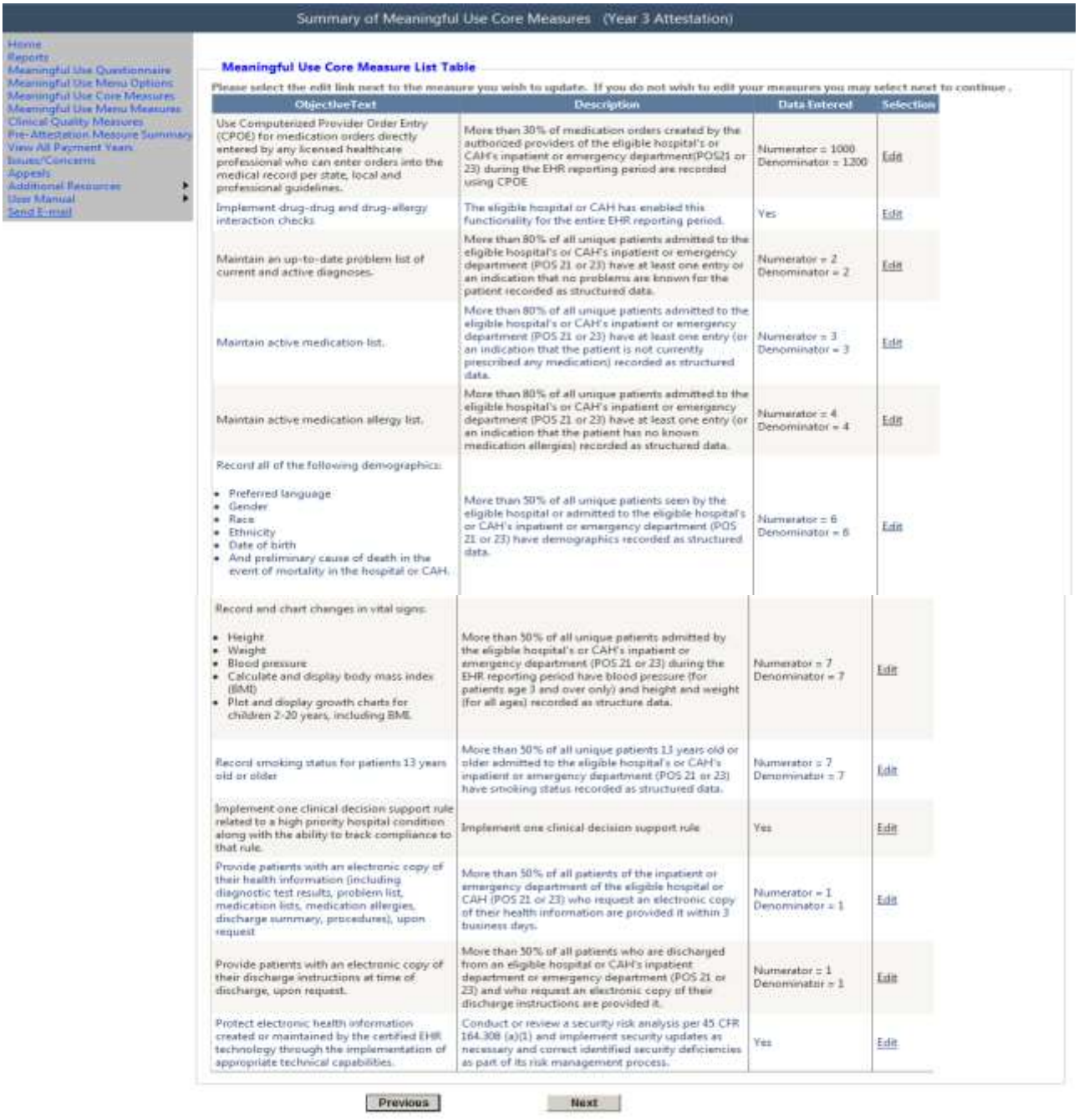


Navigation:

Logout Button – Returns the EH to the login page
Meaningful Use Core Measures Link – Takes the EH to the summary screen for Meaningful Use Core Measures
Meaningful Use Menu Measures Link - Takes the EH to the summary for Meaningful Use Menu Measures
Core Clinical Quality Measures Link – Takes the EH to the Summary of all Clinical Quality Measures
Previous – Takes the EH to the Additional Clinical Quality Measures screen
Next – Takes the EH to the Incentive Payment Calculations screen

10.40 Meaningful Use Core Measures Summary Screen

This screen lists the Objective, Measure and Data entered by the EH for each Core Meaningful Use Measure. The EH may click on Edit on a measure row to return to that Measure and update their entry.



Navigation:

Logout Button – Returns the EH to the login page
Previous – Takes the EH to the Summary of Measures screen
Next – Takes the EH to the Incentive Payment Calculations screen

10.41 Meaningful Use Menu Measures Screen

This screen lists the Objective, Measure and Data entered by the EH for each Menu Meaningful Use Measure. The EH may click on Edit on a measure row to return to that Measure and update their entry.

Navigation:

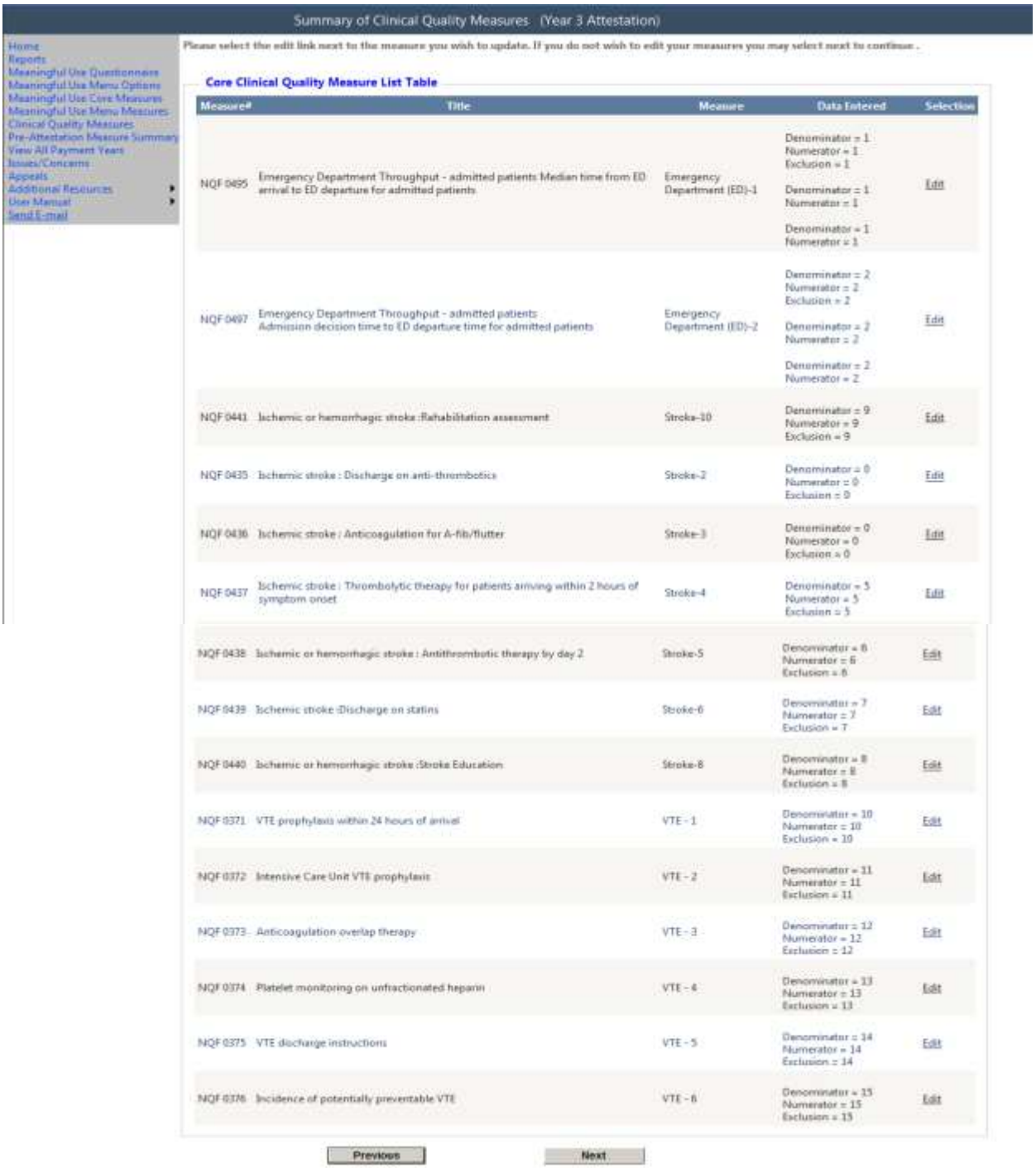
Logout Button – Returns the EH to the login page

Previous – Takes the EH to the Summary of Measures screen

Next – Takes the EH to the Incentive Payment Calculations screen

10.42 Summary of Clinical Quality Measures (CQM) Screen

This screen lists the Objective, Measure and Data entered by the EH for each Menu Meaningful Use Measure. The EH may click on Edit on a measure row to return to that Measure and update their entry.

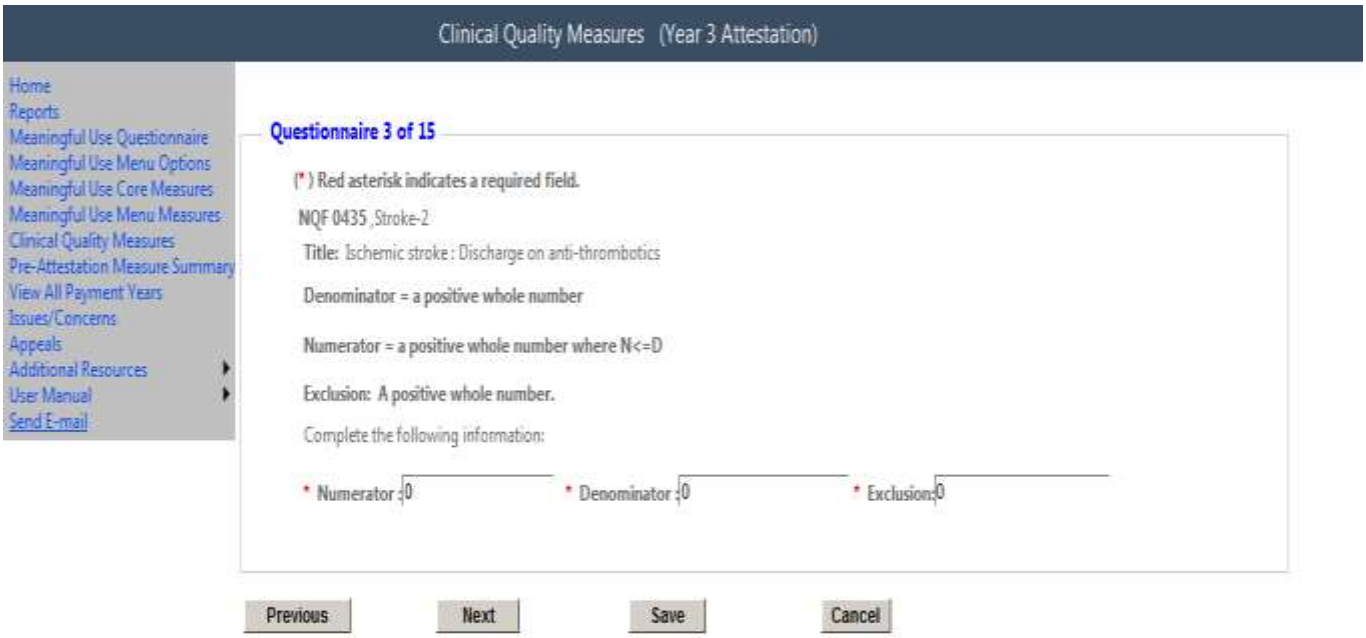


Navigation:

Logout Button – Returns the EH to the login page
Previous – Takes the EH to the Summary of Measures screen
Next – Takes the EH to the Incentive Payment Calculations screen

10.43 Measure Editing prior to Attestation

The EH may update any field on the measure that they have previously entered. The field editing for the measure will still apply upon the EH clicking save.

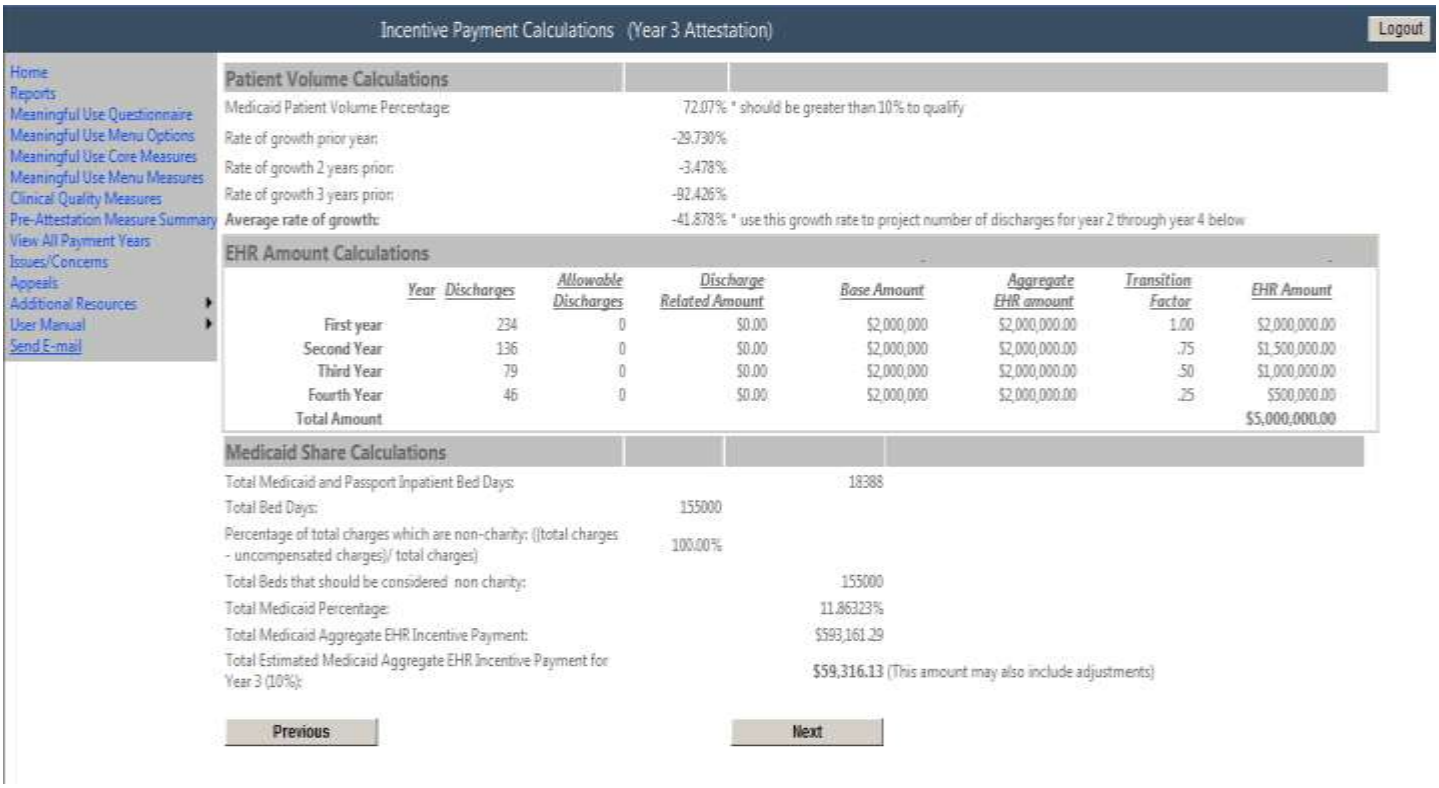


Navigation

Logout Button – Returns the EH to the login page
Save Button – Saves the data once all applicable edits are resolved.
Return to Summary Button – Takes the EH back to the Measure Summary selection page.

10.44 Incentive Payment Calculation Screen

The screen lists the estimated payment for the EH or CAH for the current attestation.



Navigation

Logout Button – Returns the EH to the login page
Previous – Return the EH to the Summary of Measures screen
Next – Takes the EH to the Document Upload screen

10.45 Documentation Upload Screen

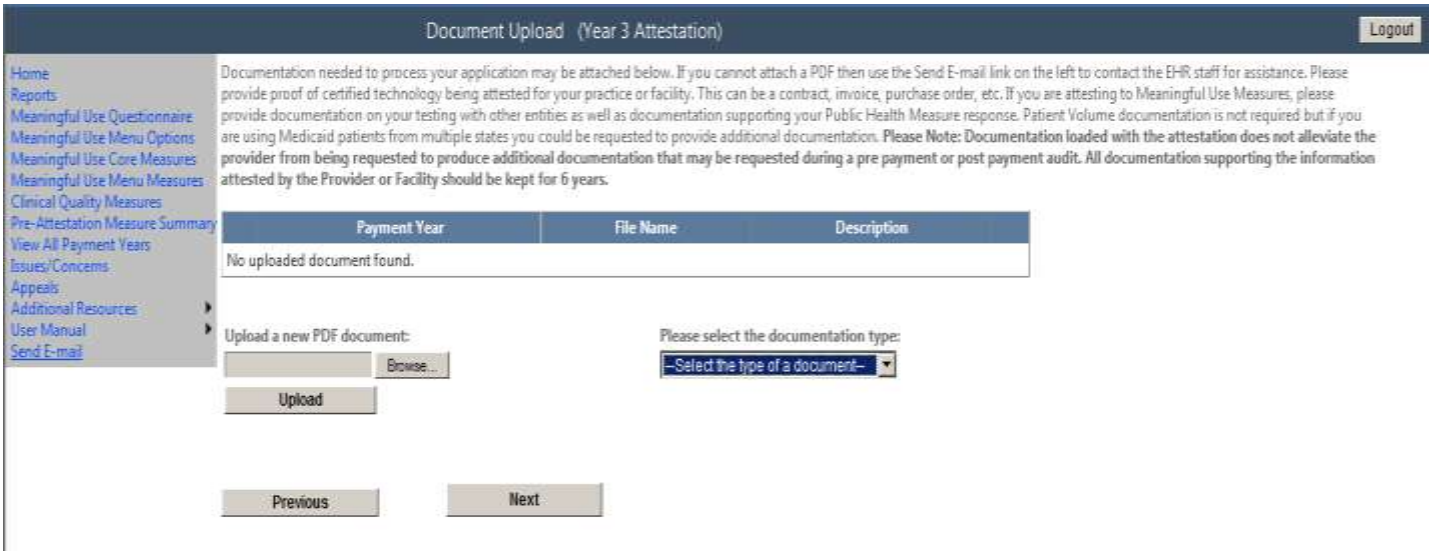
Documentation is required to support attestation review and verification. This page will allow the EH to attach documentation with their current year attestation.

- Clicking on the browse button will allow the EH to search and select the documents they would like to attach.

- Clicking on the upload button will attach and save the document relating to the current attestation payment year.

- Only PDFs that are below 100MB can be uploaded.

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre-payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

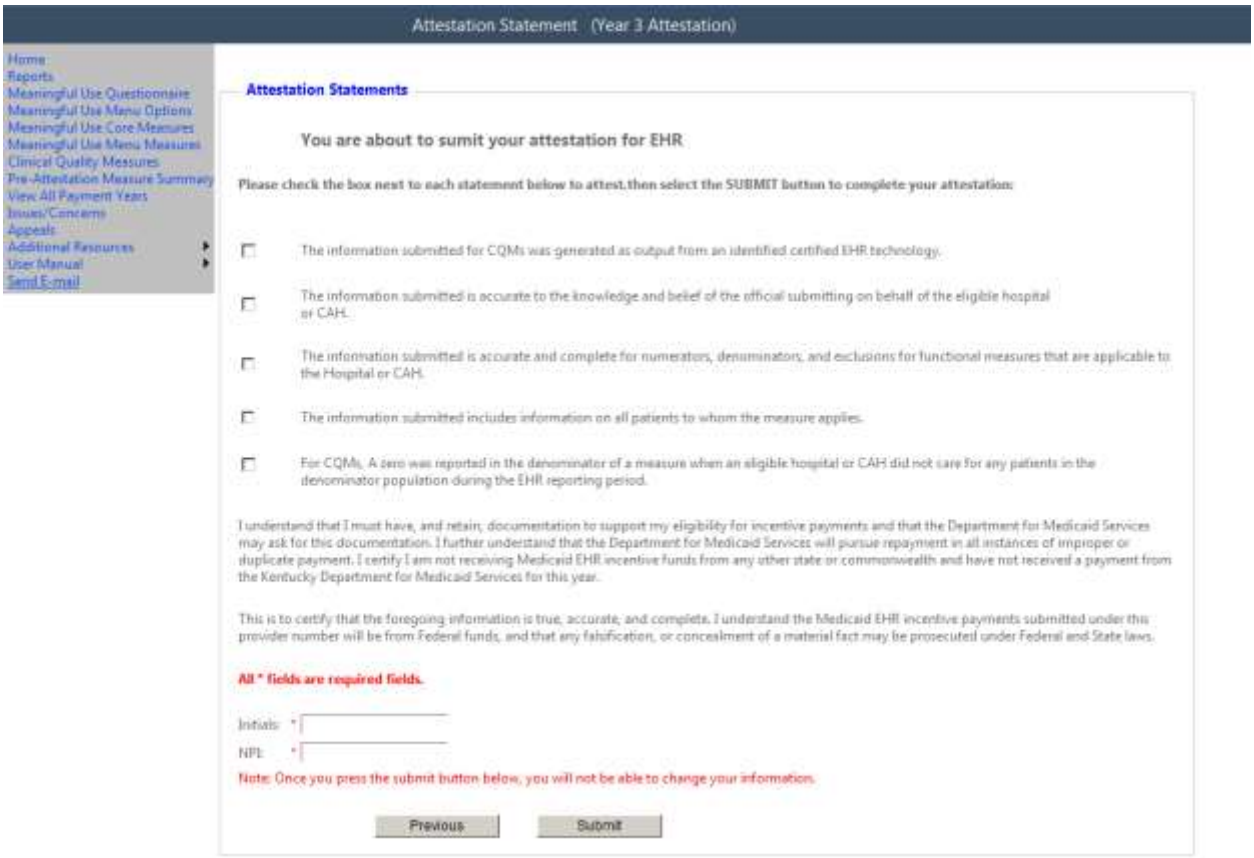


If you cannot attach a PDF, then use the Send E-mail link on the left side of the screen to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc.

If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation.

10.46 Attestation Statement Screen

The EH must check all checkboxes and enter their initials and NPI in order to submit their attestation. After initials and NPI are entered, click on the “Submit” to complete your attestation.



10.47 Accepted Attestation Screen

The EH can view their measure summaries for all measure entries. The attestation will be sent for internal review and final approval for payment.

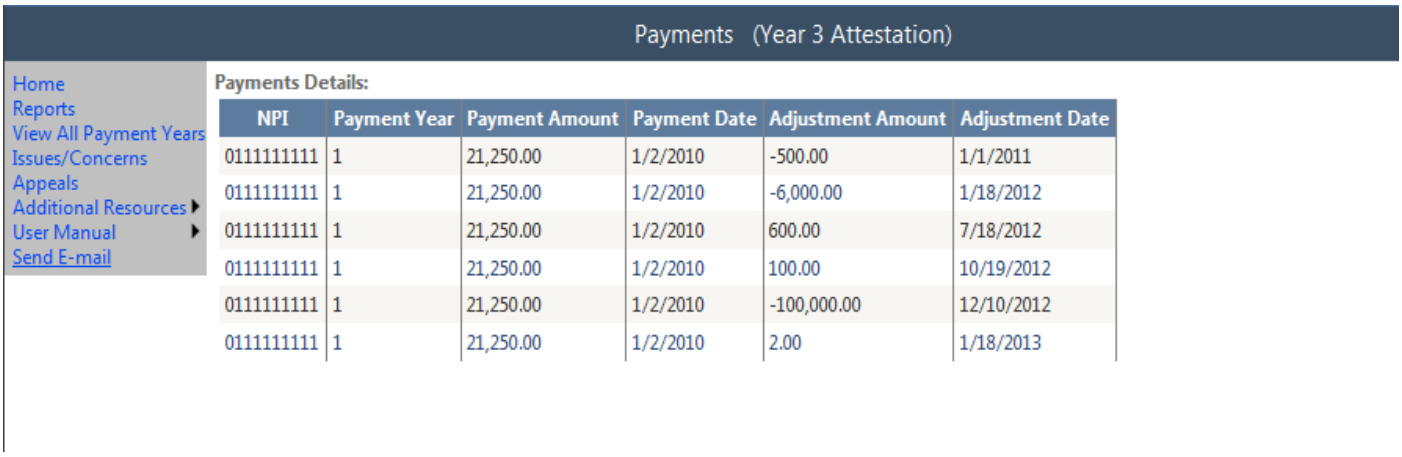
10.48 Unaccepted Attestation Screen

If your attestation is not accepted, you can review the summary of measures and look for the indication of which measure(s) were not accepted using the Unaccepted Attestation Screen. To view the summary, select the link for one of the three measures.

The EH will be allowed to re-attest once the EH is able to meet the measure requirements.

10.49 View All Payments Screen

The payments screen allows the user to view previous payments including the payment year, amount, date and type. To access the screen, click on the Payment link in the menu on the left side of the screen. This screen is a read only screen that displays any payments or adjustments made to the EH by payment year.



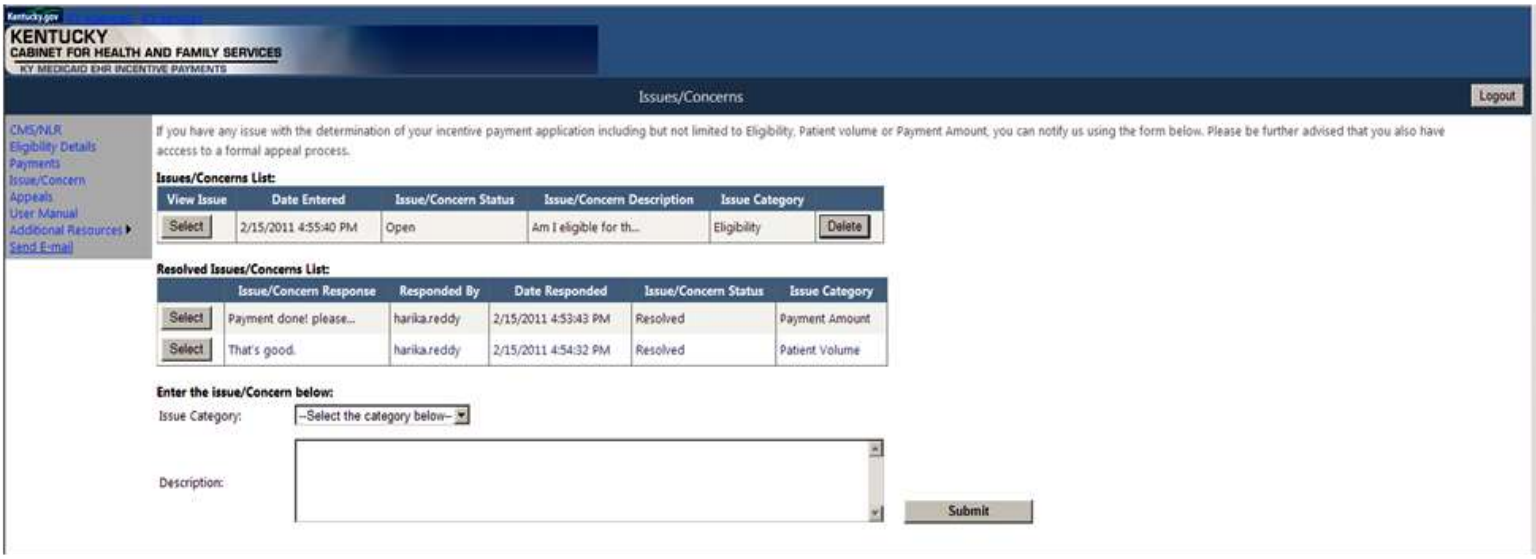
NPI	Payment Year	Payment Amount	Payment Date	Adjustment Amount	Adjustment Date
0111111111	1	21,250.00	1/2/2010	-500.00	1/1/2011
0111111111	1	21,250.00	1/2/2010	-6,000.00	1/18/2012
0111111111	1	21,250.00	1/2/2010	600.00	7/18/2012
0111111111	1	21,250.00	1/2/2010	100.00	10/19/2012
0111111111	1	21,250.00	1/2/2010	-100,000.00	12/10/2012
0111111111	1	21,250.00	1/2/2010	2.00	1/18/2013

10.50 Issues / Concerns Screen

The EH may also view and submit issues or concerns by selecting the Issues/Concerns link in the menu on the left side of the screen. The screen:

1) Displays previous issues and concerns.
2) Allows the user to view previous issues and concerns
3) Allows user to view responses to issues and concerns.
4) Allows user to submit additional issues or concerns.

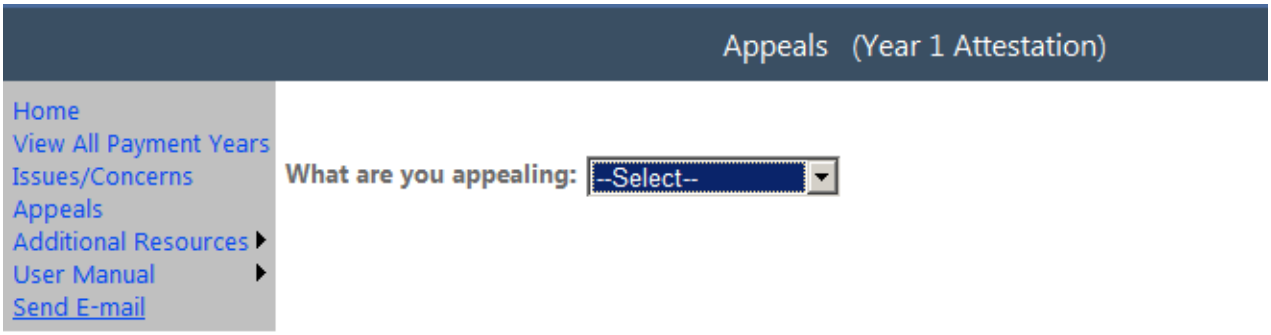
To submit Issue/Concerns, select an issue category from the dropdown list and enter the details of their issue or concern. The issue or concern will be will be saved and submitted the EHR staff upon clicking the submit button.



The EH may submit an issue or concern by selecting an issue category and typing in the details of their issue or concern. It will be saved upon them clicking the submit button.

11 AUDIT AND APPEALS

This section of the User manual includes information about features that are available to the provide from the Appeals link in the menu on the left side of the screen.

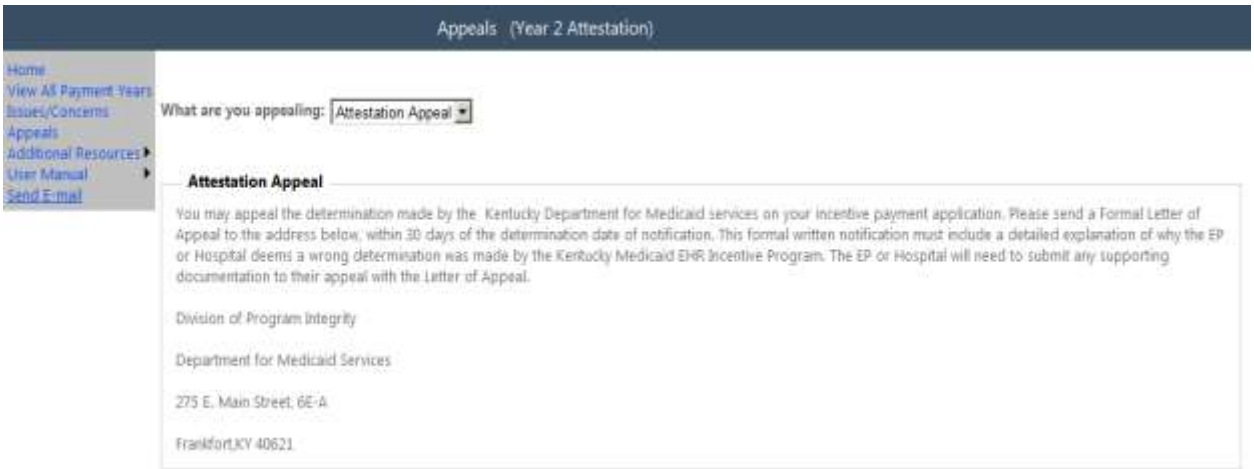


Upon selecting the "Appeals" Link from the menu on the left, the user will be given a dropdown menu to select from.

- Clicking on the Attestation Appeal option will direct the EH to a screen that will detail the process of submitting a formal letter of appeal.
- Clicking on the Audit Appeals Process will direct the EH to a screen that will show an audit grid displaying the status of any audits.

11.1 Attestation Appeals Screen

The Appeals screen informs the EH of how to initiate an appeal and provides contact information for the appeal.

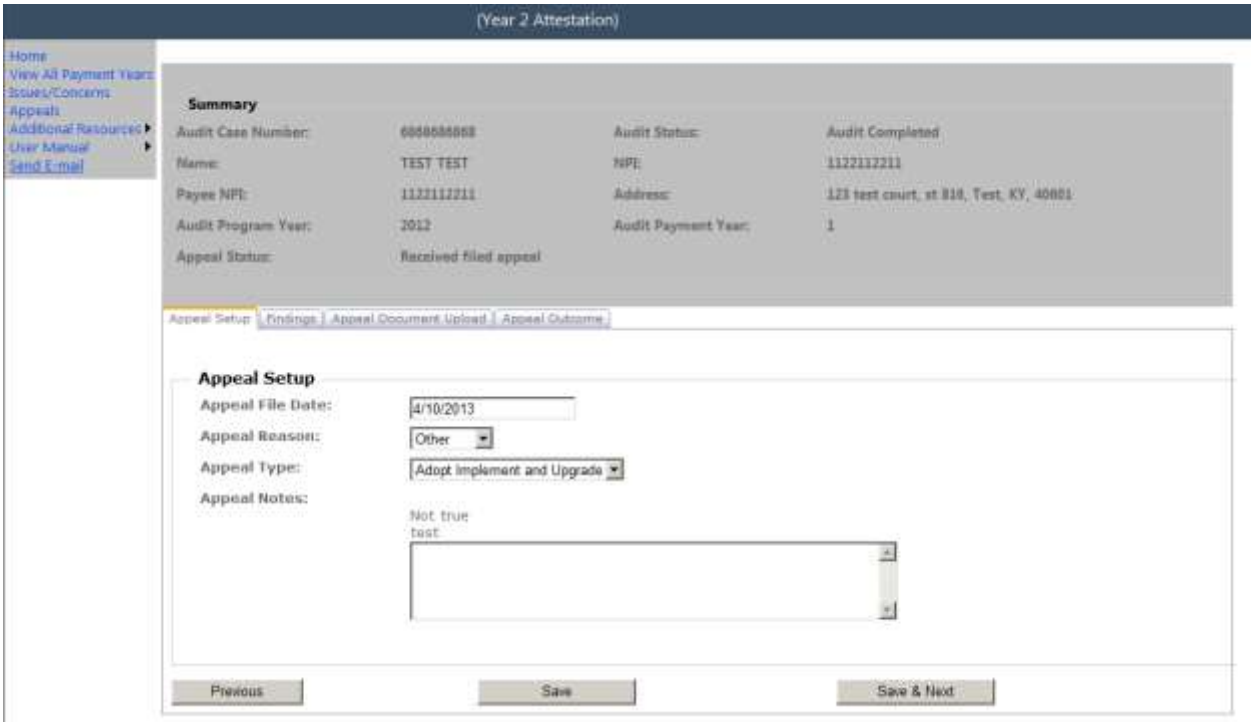


11.2 Appeals Screen – Provider Audit Appeal

If there are any audits, the user may view audit information by selecting the audit using the Select link in the row for the audit grid.

11.3 Audit Appeal Details Screen Appeal Setup Tab

If the EH would like to appeal the audit, the select Audit Appeal option from the dropdown. Select the audit to be appealed using the select button. After the provider selects the audit, screen is displayed providing a summary of the audit including case number, name, and other identifying information. The screen also displays information about the audit including status, view appeals, review findings, any appeals document that have been uploaded and view the outcome of an appeal.

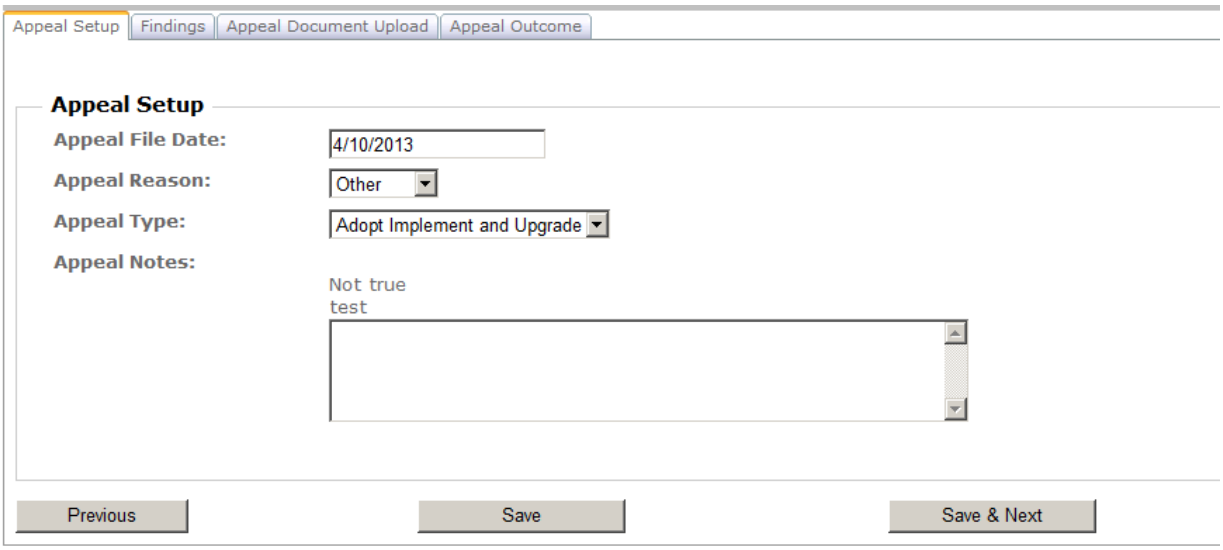


Navigation

Logout Button – Returns the EH to the login page
Previous – Takes the EH to the Appeals Screen
Save – Saves the data and displays the information on the screen above the text box.
Save and Next – Save the data and displays the information on the screen above the text box and displays the Findings tab.

To create an appeal, the user will:

1) Select the date appeal is to be filed
2) Select the type of Appeal from the drop down list.
3) Select the type of appeal from the dropdown list.
4) Enter any notes related to the appeal as text in the text box. (Maximum of 8,000 characters)

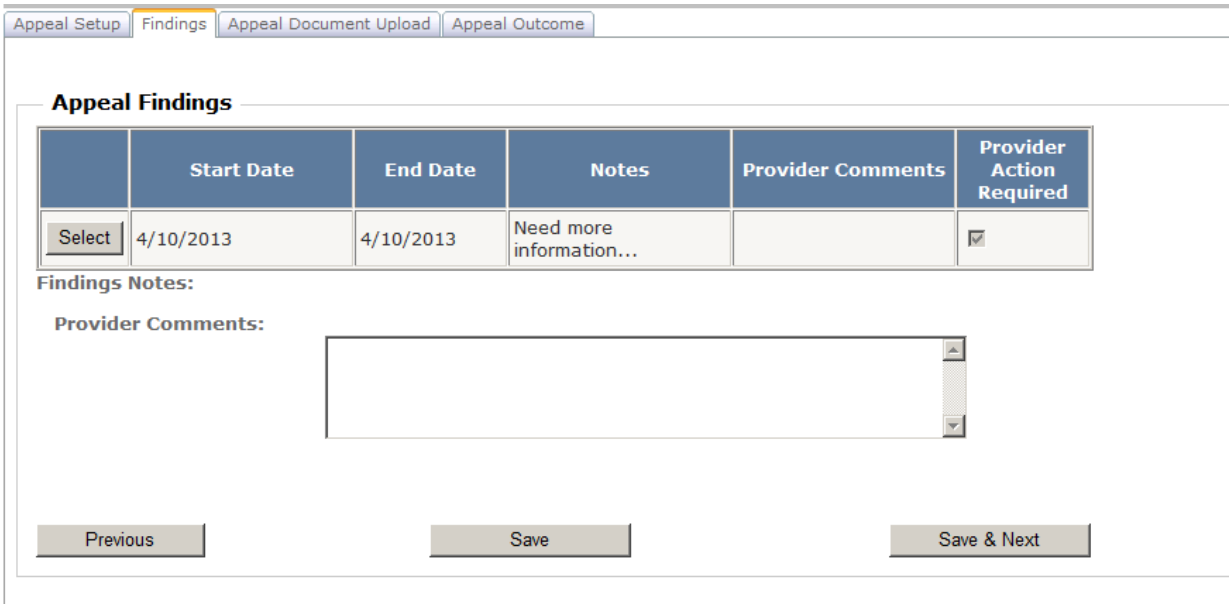


After the user completes the appeal set-up, the user may save the appeals using the Save or Save & Next buttons.

11.4 Audit Appeal Details Screen Findings Tab

The findings tab provides information about any finding related to the appeal. If there are finding, information will be displayed in the appeals finding grid including start date, end date, notes, and provider comments if any. If the audits indicated that provider action was required, then the box in the grid will have a check.

The provider may submit comments related to an appeal finding. First select the finding if more than one by clicking on the select button for the desired finding.



Enter comments in the text box labeled Provider Comments. After completing the comment click save or save and next. If the user clicks save, the comment will be displayed in the Provider comment grid.

Navigation:

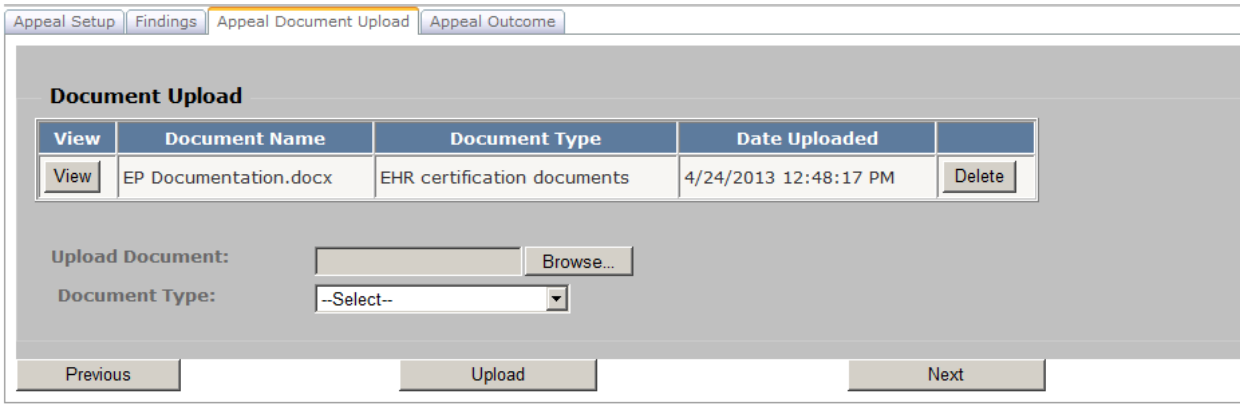
Logout Button – Returns the EH to the login page
Previous – Takes the EH to the Appeals Screen
Save – Saves the data and displays the information on the screen above the text box.
Save and Next – Saves the data and displays the information on the screen above the text box and displays the Appeal Document Upload tab.

11.4.1 Audit Appeal Details Screen Appeal Document Upload

This screen is where the EH will upload any documentation related to their audit appeal.

- User will select the "Browse" and then select the document for upload
- From the dropdown menu the user will select the document type
- Upon selection of the Upload button your Appeal information will be submitted and the document information will display in the Document Upload grid.

Note: Documents for upload are limited to PDF format and files size not to exceed 100 MB.



Navigation:

Logout Button – Returns the EH to the login page
Previous – Take the EH to the Appeals Screen
Upload – Saves the document and displays the information on the document upload grid.
Next – Displays the Appeal Outcome tab.

11.4.2 Audit Appeal Details Screen Appeal Outcome Tab

This tab will show the outcome of your appeal and include information or comments relating to your audit.